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Long Term Care

Supporting and Caring for Nova Scotians

Policy Manual

**Long Term Care Policy Manual
Table of Contents**

Policy	Date Original Policy Approved	Date of Most Recent Revision
1. Mission, Goals, & Principles	Under Development	
2. Service Eligibility Policy	November 19, 2004	January 24, 2011
3. Resident Charge Policy	December 22, 2004	November 1, 2011
4. Facility Placement Policy	March 28, 2002	January 24, 2011
5. Facility Based Respite Policy	November 19, 2004	November 1, 2011
6. Resident Trust Account Policy	January 1, 2005	May 1, 2009
7. Specialized Equipment Program Policy	January 1, 2005	July 10, 2009
8. Specialized Equipment Program Guidelines	January 1, 2005	July 10, 2009
9. Over Cost Fund Policy	January 1, 2005	February 22, 2008
10. Under 65 - LTC Pharmacare Plan Policy	April 1, 2005	
11. Special Needs Policy	December 22, 2004	December 19, 2008
12. Service Eligibility Decision Review Policy	April 25, 2003	January 24, 2011
13. Financial Decision Review Policy	November 19, 2004	May 30, 2005

For the most current version of the *Long Term Care Policy Manual* please consult the Department of Health and Wellness website www.gov.ns.ca/health/ccs .

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS CONTINUING CARE BRANCH

Subject: **Service Eligibility Policy**

Original Approved Date: November 19, 2004 Revised Date: January 24, 2011

Original signed by Keith Menzies

Approved by:

Keith Menzies, Executive Director, Continuing Care Branch

1.0 INTRODUCTION

1.1 This policy replaces Chapter 2, “Determination of Program Eligibility”, of the *Community Supports for Adults Manual* (April 1, 1998).

2.0 POLICY STATEMENT

2.1 To be eligible for admission to a long term care facility under the mandate of the Department of Health and Wellness, an individual must complete an application and meet eligibility criteria administered by the Department of Health and Wellness.

3.0 DESCRIPTION - LONG TERM CARE FACILITIES

3.1 Long term care facilities under the mandate of the Department of Health and Wellness primarily serve seniors and include Community Based Options and facilities licensed under the *Homes for Special Care Act*.

3.2 Community Based Options

3.2.1 Community Based Options (CBO) must meet the *Interim Standards for Community Based Options* and be approved by the Department of Health and Wellness. Community Based Options fall into one of the following categories:

- *Community Residences* are family homes in which accommodation and minimal supervision is provided for three or less seniors who are not immediate family of the operator. The home assists the resident in the development of self-care skills.

- *Small Option Homes* provide support and supervision for three or less seniors in a purchased or rented unit. The home assists the resident in the development of self-care skills. Trained staff are available on site at all times.

3.3 Homes for Special Care

3.3.1 Homes for Special Care are licensed by the Department of Health and Wellness pursuant to the *Homes for Special Care Act* and *Regulations*. Licensed Homes for Special Care fall into one of the following categories:

- *Residential Care Facilities* (RCF) provide supervisory care and/or personal care in a residential setting to four or more persons. Trained staff is available on site at all times.
- *Nursing Homes or Homes for the Aged*, hereinafter referred to as nursing homes, provide personal and/or skilled nursing care in a residential setting to individuals who require the availability of a registered nurse on-site at all times.

4.0 GENERAL ELIGIBILITY

4.1 An application for long term care facility admission may be made by a person who:

- (a) is lawfully entitled to be or to remain in Canada;
- (b) makes the person's home and is ordinarily resident in Nova Scotia;
- (c) meets the eligibility requirement for Nova Scotia's Health Insurance Plan (i.e. the person has been issued a valid Nova Scotia Health Card with an effective date which precedes the date of the individual's Long Term Care Facility Financial Application); and
- (d) is 18 years of age or older.

Persons 18 years of age or younger, or their authorized representative, may apply for admission to specialized long term care facilities for children.

4.2 If a person does not meet the requirements outlined in either section **4.1 (b) or (c)** above, an application may be made to the Minister or designate to have one or both of these requirements waived under the following exceptional circumstances:

- The person is residing in Nova Scotia and has made Nova Scotia their permanent home and does not yet have a valid Nova Scotia Health Card, or
- The person is a resident of another province and, for care reasons, it is not feasible to establish Nova Scotia residency prior to admission, and:
 - the person was a resident of Nova Scotia for a total of thirty (30) or more years and wishes to return to Nova Scotia to be close to family and friends, or
 - the applicant wishes to live close to his/her family supports.

Persons seeking more information on the exception request process may contact the Continuing Care Intake Office at 1-800-225-7225 or 902-424-6090.

4.3 Persons who are granted exceptional status, and who are admitted to a long term care facility under the provisions of Section 4.2, shall be responsible to :

- pay the full “facility per diem rate”, including health and accommodation costs, until the person becomes eligible for Nova Scotia Health Insurance coverage and the Department of Health and Wellness issues a Notice of Authorized Charge;
- ensure adequate financial coverage of all physician, hospital, and prescription drug expenses is in place, until becoming eligible for Nova Scotia Health Insurance and Nova Scotia Pharmacare;
- have sufficient funds to cover items of personal need such as scheduled or emergency local transportation, dental services, eyeglasses, hearing aids and any other required devices or equipment, and
- cover any and all transportation costs related to relocating for admission to the long term care facility

4.4 The person or their representative must apply for long term care services through the Department of Health and Wellness’s Single Entry Access.

4.5 Before being considered for placement in a long term care facility, an applicant must undergo:

- a comprehensive assessment to determine the type and level of care required; and
- a financial application process to determine the applicable accommodation charge for long term care services.

- 4.6 The options for placement in any particular long term care facility are determined in accordance with the level(s) of care the facility is licensed or approved to provide by the Department of Health and Wellness.

5.0 ELIGIBILITY DETERMINATION PROCESS

5.1 Referral/Intake

- 5.1.1 Referral is the initial screening process to gather the information necessary to determine whether the individual's request is appropriate for assessment for home care or for long term care placement.
- 5.1.2 A referral may be accepted from the individual or any person acting on the individual's behalf.
- 5.1.3 Where an individual is competent and refuses to give permission for the referral for intake, the Care Coordinator or the Continuing Care Referral Assistant shall not accept the referral.
- 5.1.4 If a Care Coordinator has information that an individual may be an "adult in need of protection" as defined by the *Adult Protection Act*, the Care Coordinator or the Continuing Care Referral Assistant shall report the situation to Adult Protection Services.

5.2 Functional Assessment

- 5.2.1 The individual must be willing to participate in a functional assessment (*Minimum Data Set – Home Care, MDS-HOME CARE*) prior to consideration of eligibility for the services available under Continuing Care. This process includes assessment of the person's functional, health, and social situation; and the completion of a financial application.
- 5.2.2 The purpose of the functional assessment is to determine unmet needs and to recommend an appropriate program for the individual using the most cost effective and least intrusive service plan.
- 5.2.3 The applicant must obtain and provide a Medical Status Report ninety days prior to admission to a long term care facility.

5.3 Care Level Recommendation

- 5.3.1 If, in the professional judgment of the Care Coordinator, the applicant's needs would be most appropriately met through placement to a long term care facility, the Care Coordinator shall make a recommendation with respect to an appropriate level of care, to the relevant care level determination authority, as defined in Section 3.1 of the *Facility Placement Policy*.

Care Coordinators are to recommend one of the following three options when forwarding an application for care level determination:

1. Deny application
2. RCF/CBO level care
3. Nursing home level care

5.4 Care Level Decisions

- 5.4.1 The care level determination authority shall review and interpret the application and assessment documentation and make one of the following decisions. The decision shall be documented on a *Form C-Care Level Decision For Long Term Care Facility Admissions* form.

- Deferred - Where there is insufficient information to reach a decision, the application will be deferred until additional information is available.
- Denied - If the applicant's care needs are too low or go beyond what a Department of Health and Wellness licensed or approved long term care facility can accommodate, the application is denied.
- RCF - The care needs of the applicant are consistent with the admission criteria for the category of licensed Residential Care Facility or approved Community Based Option. Generally, care is required by a person: who has decreased physical and/or mental abilities and who primarily requires supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services.
- Nursing Home Level 2 (NH2) - The care needs of the applicant are consistent with the admission criteria for the category of Department of Health and Wellness licensed nursing home. Generally, care is required by a person: with a relatively stabilized (physical or mental) chronic disease or functional disability, whose condition is not likely to change in the near future; and who requires the availability of personal care on a continuing 24 hours basis, with medical and professional nursing supervision and provision for meeting psycho-social needs.

- Nursing Home Level 1 (NH1) – Similar to NH2. The distinction between Level 1 or Level 2 depends on the degree and intensity of care and assistance required by the individual.

5.5 Eligibility Guidelines

The following are written as exclusionary criteria, outlining circumstances under which persons are generally **not eligible** to be admitted to Department of Health and Wellness licensed or approved facilities.

5.5.1 All Department of Health and Wellness Long Term Care Facilities

Individuals are not eligible for admission to Nursing Home, RCF or CBO facilities if they:

- have physical or mental illness that is not stabilized (e.g. daily medication orders, Cheyne-Stokes respirations, etc.);
- are likely to expire in the next 5 to 7 days;
- exhibit serious behavioral problems, and who might be harmful to themselves and/or others and destructive to property;
- are in acute withdrawal from substance abuse or are active substance abusers;
- are persons with communicable diseases/viral infections, which are still infectious. Exceptions to this restriction include applicants with anti-microbial resistant micro-organisms identified within the Department of Health and Wellness's *Partners For Infection Control Committee Guidelines*, (e.g. MRSA, C-Difficile, VRE). In addition, persons diagnosed with HIV or Hepatitis would be considered for admission. Long term care facilities must adhere to applicable guidelines established by Partners For Infection Control.
- have treatment needs that are not covered by Acute Home Care and which fall outside the mandate of the long term care providers (e.g. extensive dressings in which cost and frequency of nursing care are a factor.)
- have great physical difficulty in swallowing and who are at risk of aspiration, with or without food or drink.
- take their nutritional requirements other than by mouth, by gastrostomy or jejunostomy (e.g. Naso-gastric tube, TPN or IV);

- have inadequate nutritional intake. Applicants must have 800-1000cc per 24-hour period. IV should be discontinued for 2 days prior to classification to ensure this intake has stabilized. Special consideration will be given to palliative care applicants.
- have been placed on a new medication or whose medications have been significantly adjusted without sufficient time to monitor effectiveness or to ensure a therapeutic blood level where appropriate (e.g. psychiatric medications, cardiac medications, anti-convulsive medications, pain medications);
- require blood work more than 3 times a week. Exceptions may occur depending on the admission status of the applicant, the reason for and duration of the blood work required and accessibility to service within the community;
- have retention sutures. Following extensive surgery it is recommended that a classification officer or a nursing representative see the long term care applicant before classification;
- require continuous bladder irrigation;
- do not appear to require the service;
- in the opinion of care level determination authority, are not appropriate for admission to a long term care facility.

5.5.2 Residential Care Facilities and Community Based Options

5.5.2.1 Individuals are **not eligible** for admission to RCF or CBO facilities if they:

- require the services of a Registered Nurse (e.g. ongoing professional nursing assessment and care).
- cannot ambulate on their own (with or without the assistance of a cane, wheelchair, or walker).
- do not have the physical or cognitive ability to evacuate independently, in the event of an emergency (may use devices if necessary).
- require more than 1.5 hours of care of one-on-one care for supervision or assistance with activities of daily living.
- are consistently confused or an elopement risk.

- require complete assistance with activities of daily living due to confusion and/or physical impairment.

5.5.2.2 Individuals may be considered for admission to RCF or CBO facilities, in the following circumstances. Applications will be reviewed on an individual basis by the care level determination authority.

- applicants who require an indwelling catheter;
- applicants who are insulin dependent diabetics;
- applicants who require wound management care (dressing).

5.6 Placement

5.6.1 The *Form C- Care Level Decision for Long Term Care Facility Admissions* form is provided to the Placement Coordination Office and the applicant's Care Coordinator. The applicant is informed by the Care Coordinator of the care level decision.

5.6.2 If the care level decision is "NH2" or "NH1", the applicant may be placed to a nursing home that is suitable to meet the applicant's specific care needs. If the care level decision is "RCF", the applicant may be placed to a residential care facility or community based option that is suitable to meet the applicant's specific care needs.

5.6.3 The Care Coordinator informs the Placement Coordination Office of the applicant's specific care needs (e.g. dementia care, etc.) and facility preferences. The Placement Coordination Office arranges admission in accordance with Continuing Care's *Facility Placement Policy*. Placement ensures that care needs are met first and, where possible, facility preferences are accommodated.

6.0 **TEMPORARY ABSENCES**

6.1 A long term care facility may approve the holding of a resident's bed to allow the resident to visit family for a period generally not to exceed 30 days per year.

6.2 At the request of the resident or authorized representative, a long term care facility may approve the holding of a resident's bed when a resident is transferred to a health care facility if, based on the resident's prognosis, the resident is expected to return to the facility within thirty days.

- 6.3 For residents transferred to a health care facility, a resident's long term care bed may be held for longer than thirty days if:
- the facility provides the resident's Care Coordinator a written prognosis explaining the need for an absence beyond 30 days; and
 - the Care Coordinator forwards the written request and supporting documentation to the Supervisor for approval.

6.4 The resident will be responsible for the accommodation charges during their absence from the facility. Beds held in accordance with this policy shall not be used during the resident's absence.

7.0 TRANSFERS

7.1 Movement of a resident from one category of facility or level of care to a different category of facility or level of care is considered a new placement, not a transfer. In such instances, a new application shall be completed.

7.2 Additional information on transfers may be found in Continuing Care's *Facility Placement Policy*.

8.0 CHANGE IN RESIDENT CARE NEEDS

8.1 If a long term care facility operator finds that a resident's care needs can no longer be safely met at the long term care facility, he/she shall work with the resident, the resident's family, Continuing Care staff and the resident's physician to secure appropriate care arrangements at an alternative setting.

8.2 If a long term care facility operator or the Department of Health and Wellness facility inspector suspects that a resident does not meet the Department of Health and Wellness's admission criteria, but believes that the facility can continue to provide safe and appropriate care to the resident, he or she shall report this situation to the Director, Monitoring and Evaluation, Continuing Care Branch, who shall:

- ensure that an assessment of the resident is conducted by the appropriate health professionals;
- determine, in collaboration with the facility operator, the facility's capacity to serve the client; and

- provide direction to the facility operator on the appropriate action to be taken. This may or may not include the relocation of the resident to another long term care facility more appropriate to meet the resident's care needs.

Policy: RESIDENT CHARGE POLICY

Approval Date: October 31, 2011

Effective Date: November 1, 2011

Approved by: *Original signed by Kevin McNamara*

Kevin McNamara, Deputy Minister of Health and Wellness

Version Control: Replaces March 30, 2011 version

1.0 INTRODUCTION

Residents admitted to facilities licensed or approved by the Department of Health and Wellness pay the “accommodation” portion of their long term care costs. Residents may apply to have the Standard Accommodation Charge reduced, subject to an income test. Residents retain assets and income to pay for items of personal need or enjoyment.

Note: For long term care facilities licensed or approved by the Department of Health and Wellness, this policy replaces Chapter 3 - Determination of Financial Eligibility, in the *Community Supports for Adults Manual* (April 1, 1998).

2.0 PURPOSE

The purpose of this policy is to describe how resident charges are determined for persons living in Department of Health and Wellness long-term care facilities.

3.0 APPLICATION OF POLICY

3.1 The Resident Charge Policy applies to regular bed applicants or residents of one of the following three types of long term care facilities that exclusively admit applicants assessed and referred by the Department of Health and Wellness.

- Nursing Homes/Homes for the Aged (hereinafter referred to as “nursing homes”) licensed by the Department of Health and Wellness,
- Residential Care Facilities (RCFs) licensed by the Department of Health and Wellness,
- Community Based Options (CBOs) approved by the Department of Health and Wellness.

3.2 The term “regular bed” is used to refer to beds that are licensed/approved by the Minister of Health and Wellness for the purpose of providing care and accommodation to individuals who are not expected to be discharged to the community in the short term. Regular beds are distinguished from “respite beds”.

For information on charges pertaining to “respite bed” applicants, refer to the Facility Based Respite Policy in the *Long Term Care Policy Manual*.

4.0 ALLOWABLE CHARGES

4.1 Facility Per Diem Rate

4.1.1 The Department of Health and Wellness reviews the detailed budgets of each long term care facility on an annual basis and individually sets a “facility per diem rate” that covers both “health care costs” and “accommodation costs”.

4.1.2 “Health care costs” are costs approved by the Department of Health and Wellness and include salaries, benefits, and operational costs of resident care. Costs may be related to: nursing and personal care, social work services, and physical, occupational, recreation, and other therapies.

4.1.3 “Accommodation costs” are costs approved by the Department of Health and Wellness and include:

- salaries, benefits, and operational costs of: maintenance, dietary services, housekeeping, management, and administration departments;
- capital (principle, interest and depreciation), including mortgages, equipment and small projects; and
- return on investment.

4.2 Insurer of Last Resort

4.2.1 The Department of Health and Wellness is the payer of last resort for “health care costs” and “accommodation costs”

4.2.2 The full “facility per diem rate” is the rate charged to individuals who are:

- Provided for by the court or through an award or benefit.

Where a disability necessitating long term care placement is due to an illness or injury and the applicant has received or is pending receipt of a sum of money through a liability award or settlement for future care, the applicant is considered a private payer and is charged the full cost of care and accommodation.

- Once the amount identified for future care by the court or through an award or settlement is expended on care, the applicant can apply for a reduced accommodation charge. At the point of financial reassessment, any remaining funds which were awarded for damages other than future care, such as wage loss or for pain and suffering, are considered part of the applicant’s income.
- Provided for under any other statute;
- The responsibility of :
 - Veterans Affairs Canada;
 - the Workers Compensation Board; or
 - the Federal Government or First Nations individuals living on Reserve in Nova Scotia with a band number.

4.3 Standard Accommodation Charge

4.3.1 Based on a review of the average “accommodation costs” for each of the three types of long term care facilities, the Department of Health and Wellness annually sets a provincial Standard Accommodation Charge for each type of facility. The total approved budget for items included as accommodation costs are summed for all facilities of a particular type (e.g. nursing home) and then divided by the total number of resident days in all facilities of that type to arrive at a daily Standard Accommodation Charge.

4.3.2 The Standard Accommodation Charge for each type of long term care facility shall be set annually by the Department of Health and Wellness and shall be effective for a twelve month period from November 1st to October 31st of the following year.

- 4.3.3 The Standard Accommodation Charges effective November 1, 2011 are:
- Nursing Homes - \$99.00 per day.
 - Residential Care Facilities - \$61.00 per day
 - Community Based Options - \$49.50 per day.
- 4.3.4 With the exception of those who are subject to the “facility per diem rate” under section 4.2, the “health care costs” are provincially funded and the resident pays the authorized accommodation charge as determined by the Department of Health and Wellness.
- 4.3.5 Long term care facilities are prohibited from charging any resident more for accommodation than the amount determined by the Department of Health and Wellness.
- 4.3.6 Long term care facilities are prohibited from charging extra for private or semi-private accommodation.
- 4.3.7 Long term care facilities must provide a full and clear explanation of Basic Services for which the resident cannot be charged and a fee schedule for Optional Services. The list of Basic Services and the Optional Services fee schedule must be provided to the resident/authorized representative at admission and at any time the schedule changes.

See “Appendix A” for a description of Basic Services and an explanation of Optional Services.

4.4 Day of Billing

- 4.4.1 A long term care facility is permitted to levy an accommodation charge on the resident for the day of admission and the day of death.
- 4.4.2 The long term care facility is not permitted to levy an accommodation charge on a resident for the day of discharge.
- 4.4.3 For the purposes of billing, the day of admission may be the day the applicant is physically admitted to the facility **or** the day the applicant agrees to pay to hold a bed for his or her imminent admission.
- 4.4.4 A day means a twenty-four hour period that begins at 12:01 a.m. and ends at midnight.

5.0 FINANCIAL APPLICATION

5.1 Mandatory Completion

5.1.1 The Long Term Care Facility Financial Application (hereinafter referred to as “financial application”) must be completed. A financial application may be made by an individual, or someone authorized to act on the individual’s behalf.

5.1.2 With the exception of clients determined to be Adults in Need of Protection in accordance with the Adult Protection Act, failure to complete the financial application shall result in the refusal of admission to long term care facilities.

5.2 Application Completion Process

5.2.1 For each person requesting admission to a long term care facility, the District Health Authority will:

- Explain the authorized accommodation charge;
- Explain the income test process, if the person is requesting a reduction in the Standard Accommodation Charge;
- Complete the application package with the applicant or authorized representative.

5.2.2 The application package is forwarded to the Eligibility Review Unit, Continuing Care Branch, Department of Health and Wellness for completion of the income test process and to determine the applicant’s authorized accommodation charge.

5.2.3 The authorized accommodation charge is communicated to the applicant in a *Notice of Authorized Charge* letter from the Eligibility Review Unit. The authorized accommodation charge is communicated to the admitting long term care facility by the Eligibility Review Unit.

5.3 Agreement to Pay Standard Accommodation Charge

5.3.1 Individuals who do not wish to be considered for a reduction in the Standard Accommodation Charge are not required to undergo an income test, but shall indicate on the Financial Application their agreement to pay the Standard Accommodation Charge.

5.4 Applying for a Reduced Accommodation Charge

- 5.4.1 If the value of 85% of an applicant's assessed income is greater than the Standard Accommodation Charge, the applicant shall not be eligible for a rate reduction.
- 5.4.2 Should an individual wish to be considered for a reduction in the Standard Accommodation Charge, the Department of Health and Wellness requires the applicant or his/her legal representative to sign a Department of Health and Wellness *Consent to Release Tax Payer Information*.

To expedite the process, applicants are encouraged to provide the Canada Revenue Agency (CRA) *Notice of Assessment* or *Income Tax Summary* for the tax year that corresponds to the assessment period designated by the Department of Health and Wellness.

- 5.4.3 If an individual has not filed an *Income Tax and Benefit Return* with the CRA, the Department of Health and Wellness may accept alternative documentation that adequately meets the Department's information requirements.
- 5.4.4 An income test will be completed annually to determine continued eligibility for a reduced accommodation charge. The client is required to file a tax return. If the client or someone authorized to act on the client's behalf has signed the "Consent to Release Tax Payer Information" form, the Department of Health and Wellness can access the Notice of Assessment directly from CRA. If the form has not been signed, then the client must provide the CRA *Notice of Assessment* or *Income Tax Summary* for the tax year that corresponds to the assessment period designated by the Department of Health and Wellness.
- 5.4.5 Residents are required to provide income information on an annual basis in order to remain eligible for a reduction in the Standard Accommodation Charge. Residents who do not provide the required information by June 30th shall be assessed the Standard Accommodation Charge. Should additional income information become available at a later date, residents may apply for a reduction to the Standard Accommodation Charge by providing supporting income information. Any approved adjustments to the Standard Accommodation Charge shall be effective for the time period in which the supporting income information is relevant.
- 5.4.6 Sponsored immigrants are not eligible for a reduction in accommodation charges and are required to pay the Standard Accommodation Charge.

5.5 Income Testing

- 5.5.1 Eligibility for a reduced accommodation charge will be determined by the application of an income test.
- 5.5.2 The purpose of the income test is to assess eligibility for a reduction in the accommodation rate, determine the amount of the rate reduction and to monitor ongoing eligibility.
- 5.5.3 Applicants or residents applying for a reduction in the accommodation charge will be income tested at the time of application and annually thereafter.
- 5.5.4 Each resident shall be notified by the Department of Health and Wellness of any change in the accommodation charge resulting from the annual income test at least 30 days prior to the effective date of the change.
- 5.5.5 It is the responsibility of the applicant/resident or authorized representative to advise the Department of Health and Wellness of any changes in financial or marital status within 30 days of the change. A review will be completed and the new accommodation charge may be applied retroactively to the effective date of the change. Documentation may be required to support any changes.
- 5.5.6 A financial review may be undertaken at any time, where the Department receives information related to the individual's income that may affect the individual's authorized accommodation charge (e.g., death of spouse; applicant/resident and/or spouse turns 65 years of age). The new accommodation charge may be applied retroactively to the effective date of the change.

5.6 Provision of Information

- 5.6.1 It is the responsibility of the applicant/authorized representative to provide all information required to enable the Department of Health and Wellness to make a determination of financial obligation.
- 5.6.2 The applicant or any other person may be the subject of legal action by the Province to recover funds if, at any time the person:
- willfully withholds information on an applicant's income;

- under reports the amount of an applicant's income; or
- provides false or misleading information on an applicant's income which results in the applicant obtaining a reduced accommodation charge to which the applicant is not entitled.

5.7 Requests to Reduce Assessed Income

5.7.1 Once admitted to a long term care facility, the resident shall not transfer or reduce income in order to qualify for a lower accommodation charge.

5.7.2 Upon providing the Department of Health and Wellness with sufficient documentary evidence, the applicant/authorized representative may request that the Department of Health and Wellness accept a lower income level and reduce a resident's accommodation charge if the higher income level resulted from:

- a one-time payment of surplus pension funds from the Cape Breton Development Corporation;
- the Canada Pension Plan one-time death benefit;
- retroactive income for years preceding the tax year used in the assessment;
- lower interest, currency exchange rates and dividend rates,
- liquidation of an income generating asset, when the funds are used to cover care costs;
- Department of Health and Wellness payments through the Caregiver Benefit Program;
- liquidation of an income generating asset to prepay funeral expenses up to the maximum stated in the Funeral Schedule of the Department of Health and Wellness' Special Needs policy. Receipts or documentation must be provided to confirm funeral prepayment expenses;
- a one-time payment from the Indian Residential School Settlement; or
- mandatory employment deductions (i.e., union fees, EI, CPP, and registered pension plan) of the spouse in the community for that tax year.

5.7.3 The Department shall not assume responsibility for an individual's indebtedness (e.g. loans, household personal expenses, monthly bills, bankruptcy).

5.7.4 Where an applicant/resident's financial affairs are managed by the Office of the Public Trustee and their liquid monetary assets are less than \$4000, the Department shall deduct Public Trustee fees from the applicant's assessed income before determining an authorized accommodation charge.

5.8 Maximizing Income

5.8.1 To be eligible for a reduction in the Standard Accommodation Rate the applicant must apply for the maximum level of all income for which they are eligible. The applicant's spouse must also maximize income in cases of income splitting.

5.8.2 Income sources that may be available include, but are not limited to, the Federal government's Old Age Security, Guaranteed Income Supplement (GIS) and Canada Pension Plan benefits.

- Guaranteed Income Supplement benefits may be increased for married couples that have to live apart for care reasons, referred to as Involuntary Separation. The couple's marital status is not changed. In these cases, the couple applies to the Federal government for an increase in their GIS benefits by informing the Federal government of their new circumstances.

5.9 Definition of Assessed Income

5.9.1 Income is assessed based on the applicant's, and if applicable the spouse's, "net income" less "total taxes payable" as reported to the Canada Revenue Agency (line 236 less line 435) on the *Income Tax and Benefit Return*.

5.9.2 If circumstances related to the applicant's, and spouses if applicable, income have changed since his/her last Notice of Assessment (e.g., deceased spouse, applicant turns 65 years of age, etc.), the Department of Health and Wellness may exercise the discretion to calculate the accommodation charge based on the applicants current income. This new accommodation charge may be applied retroactively to the effective date of the change.

5.10 Minimum Retained Income

5.10.1 Minimum Retained Income (MRI) is the annual amount that, at a minimum, each adult applicant shall be left with as retained income.

5.10.2 Effective November 1, 2011, the annualized Minimum Retained Income (MRI) amount is \$2,976.00. The Minimum Retained Income amount shall be adjusted annually by a rate equivalent to the annual rate of change to the Federal Old Age Security, Guaranteed Income Supplement and Canada Pension Plan payments.

5.11 Accommodation Charge - Single, Widowed or Divorced Applicant

5.11.1 Eighty-five percent (85%) of an applicant's assessed income will be applied to the accommodation charge. However, no adult applicant's annual income shall fall below the Minimum Retained Income level defined by the Department of Health and Wellness.

5.11.2 If the applicant's assessed income is less than the Minimum Retained Income amount, the Department of Health and Wellness shall supplement the applicant's income to the Minimum Retained Income amount, in accordance with the following procedures:

- On the first day of each month when the person is residing at the facility on that day, the facility bills the Department of Health and Wellness one-twelfth of the annualized Minimum Retained Income amount, less one-twelfth of the person's assessed annual income.
- For persons transferred from another approved/licensed facility, the admitting facility bills the Department of Health and Wellness commencing on the first day of the next calendar month following the day of admission.
- The bill to the Department of Health and Wellness is not pro-rated for partial month stays.

5.12 Accommodation Charge - Married, Common Law Partners, Domestic Partnerships

5.12.1 All applicants who have a "spouse" and seek a reduction in the Standard Accommodation Charge must, along with their spouse, undergo an income test. The assessed income of the applicant and their spouse are combined and then divided into two equal portions.

5.12.2 A spouse in relation to an applicant includes a person to whom the applicant is married, a common law partner or a domestic partner. As it relates to the above definition of spouse, a common law partner or domestic partner is a person to whom an applicant cohabited with in a conjugal relationship for at least one year immediately before the application for admission to a long term care facility was made. Further, a domestic-partner is a person who is party to a registered domestic partners declaration pursuant to Nova Scotia's *Vital Statistics Act*.

- 5.12.3 The Spousal Income Threshold is the amount set by the Department of Health and Wellness each November 1st to be the equivalent value of maximum Old Age Security and Guaranteed Income Supplement pension at the end of the previous tax year plus the Minimum Retained Income amount. The Spousal Income Threshold effective November 1, 2011 is \$18,064.00 per year, or an average of \$1,505.33 per month.
- 5.12.4 If after a couples' assessed income is divided into two equal portions, the applicant's spouse is left with less than the Spousal Income Threshold amount, the Department of Health and Wellness may allow more of the applicant's income to remain with the applicant's spouse by further reducing the accommodation charge. However, the applicant's retained income shall not be reduced below the monthly Minimal Retained Income amount. The Department of Health and Wellness shall not reduce the applicant's accommodation charge in order to increase the income of the applicant's spouse to be an amount higher than the Spousal Income Threshold.
- 5.13 Accommodation Charge - Allowance for Dependants
- 5.13.1 An applicant's spouse may retain an additional amount of the couples' assessed income equivalent to fifty percent of the Spousal Income Threshold for each "dependant". However, the applicant's retained income shall not be reduced below the Minimum Retained Income amount.
- 5.13.2 A "dependant" in relation to an applicant is an individual other than a spouse who qualifies to be claimed, and is claimed, as a dependant exemption on the *Income Tax and Benefit Return* of the applicant or his/her spouse.
- 5.13.3 There must be a spouse in the community to care for the dependent.
- 5.13.4 The dependant must be a child under the age of majority, or if older than 19 years and younger than 25, be attending school full time (proof is required). If the child is a disabled adult, proof is required that the dependant is claimed on the client's or spouse's income tax return as a dependant exemption.
- 5.13.5 Any income received by the dependant would be used to reduce the amount of dependant deduction allowable for the client's accommodation charge.

5.14 Accommodation Charge - Adult Protection Clients

5.14.1 Every effort is made to have the financial application completed and a resident accommodation charge established before the placement of an adult in need of protection is made. In some circumstances however, clients of the Department of Health and Wellness's Adult Protection Services may have to be placed prior to the completion of a financial application.

5.14.2 For Adult Protection clients who are placed prior to a determination of the client's financial responsibility for costs, the following shall apply, until the completion of the financial application process.

The Department of Health and Wellness shall continue to work with the resident/authorized representative to complete the financial application process.

The long term care facility shall attempt to redirect the resident's income to the facility for application toward their personal and accommodation costs.

Where the long term care facility has been unsuccessful at redirecting the resident's income, the facility may bill the Department of Health and Wellness for an amount equivalent to the Minimum Retained Income, provided that the Public Trustee, a court appointed guardian, a power of attorney, or a family member is not involved in managing the resident's financial affairs.

Between the date of placement and the date that the financial assessment is completed, the long term care facility shall not be responsible to collect an accommodation charge amount from the resident.

The resident shall be reported as an Adult Protection client with a \$0 accommodation charge on the Long Term Care Billing Details report until such time as an accommodation charge is established. Once an accommodation rate is established, the individual would be reported as a new policy resident, with an identified accommodation charge.

5.14.3 For residents subject to Section 5.14.2, once the financial application process is completed and a resident accommodation charge established, the Department of Health and Wellness shall:

- require the facility to commence billing the resident/authorized representative; and

- be responsible to recover from the resident/authorized representative any costs which were paid for by the Department of Health and Wellness and which are assessed to be the resident's responsibility, including accommodation charges for the period between placement and completion of the financial assessment.

6.0 PRE-2005 PUBLICLY ASSISTED RESIDENTS

- 6.1 Any resident who is in a regular bed and who was residing in a long term care facility prior to January 1, 2005 and who was receiving financial assistance from the Department of Health and Wellness exceeding \$12.75 per day, shall be referred to as a "publicly assisted" resident for the purpose of this policy.
- 6.2 At any time, the "publicly assisted" resident may inform the Department of Health and Wellness in writing that he/she wishes to be assessed under the new policies. The resident's decision shall be recorded on a Department of Health and Wellness approved form. The resident's decision shall take effect 30 days from the date that the Department of Health and Wellness receives the resident's request form. A resident's decision to be assessed under the new policies cannot be reversed.
- 6.3 A "publicly assisted" resident who transfers between Department of Health and Wellness's licensed/approved long term care facilities or is discharged from a long term care facility to hospital and then is subsequently readmitted to a long term care facility shall retain their "publicly assisted" status.
- 6.4 The "publicly assisted" option **is not** available to persons who:
- were not long term care facility residents at December 31, 2004.
 - were long term care facility residents who did not receive financial assistance greater than \$12.75/day from the Department of Health and Wellness at December 31, 2004.
 - were residents of respite beds,
 - were discharged from a long term care facility to the community and subsequently were readmitted to a long term care facility.
- 6.5 "Publicly assisted" residents shall continue to:
- have their regular recurring "actual income" sent in their name to the address of the facility and then redirected to the facility for application against the Standard Accommodation Charge;
-

- receive the special needs benefits for which they are eligible under the Special Needs Policy in the *Long Term Care Policy Manual*; and
- receive a monthly Personal Use Allowance (PUA), unless the resident meets the exclusion criteria outlined in section 6.8 of this policy.

6.6 An authorized representative of the resident may sign an agreement with the long term care facility to take responsibility for the payment of the resident's regular recurring "actual income" to the facility in lieu of having the resident's income directly sent to the facility from the income source. In such cases, the authorized representative must agree in writing to:

- on a monthly basis, pay all the resident's actual income to the facility
- on a quarterly basis, submit an actual income statement to the facility on the prescribed form, and
- on an annual basis, submit the residents CRA taxation Notice of Assessment to the facility.

If the authorized representative fails to provide all of the resident's actual income to the facility, the agreement will be considered null and void and the payment arrangement would revert back to the method detailed in section 6.5 of this policy.

6.7 The term "actual income" includes but is not limited to

- public and private domestic and foreign pensions;
- transfer payments from any level of government (e.g. OAS, GIS, CPP, Workers Compensation, Veterans' Allowance);
- business revenues;
- investment income (e.g. interest and dividends);
- loan repayments from family members;
- income from a trust fund; and

- any other form of monies received with the exception of:
 - GST refunds,
 - lump sum compensation payments for Merchant Mariners in World War II,
 - veterans disability pensions,
 - income earned by the spouse,
 - ownership of a private business by a spouse,
 - refundable child care credit, and
 - Federal child tax benefits.
- 6.8 If the “publicly assisted” resident’s “actual income” exceeds the Standard Accommodation Charge, the facility shall return the excess income to the resident. If the excess income is equal to or exceeds the equivalent value of the Personal Use Allowance, the resident will not be eligible for a PUA. If the resident has excess income that is less than the PUA, the Department of Health and Wellness will issue a partial PUA to ensure that the combined value of the partial PUA and the excess income is equivalent to the value of a full PUA.
- 6.9 For “publicly assisted” residents who have a spouse, any income split approved prior to January 1, 2005 shall continue to be in effect. If the couple seeks an adjustment to the income split after December 31, 2004, the Department of Health and Wellness shall consider the assets and income that were assessed in the original decision as well as the spouse’s current income and expenses.
- 6.10 On an ongoing basis, it is the responsibility of the facility to report all resident income that is redirected to the facility and if a resident’s regularly recurring income is not received by the facility, it is the responsibility of the facility to ensure immediately that the income is recovered and applied to the costs of care.
- 6.11 In the month of death or discharge, the facility shall charge the “publicly assisted” resident the Standard Accommodation Charge for each day the resident occupied a bed at the facility, as long as the resident’s assessed income is sufficient. Any excess income shall be returned to the resident or their estate.
- 6.12 Residents:
- who were in a long term care facility for a period before January 1, 2005; and
 - who were assessed as having sufficient assets and income to cover the full per diem rate for the period of their stay that preceded January 1, 2005; but

- who received financial assistance greater than \$12.75/day from the Department of Health and Wellness because some or all of their assets were unavailable (e.g. locked in Guaranteed Investment Certificate)

shall continue to be responsible for paying the costs of the full per diem rate for the period preceding January 1, 2005.

This means that, as accumulated income and/or assets become available, the Department of Health and Wellness shall recover from the resident/authorized representative the costs of care which were paid by the Department of Health and Wellness and which were assessed to be the resident's responsibility.

7.0 Accountability

The Executive Director, Continuing Care Branch is responsible for ensuring compliance with this Policy.

8.0 Monitoring

The implementation, performance, and effectiveness of this Policy will be monitored by the Executive Director, Continuing Care Branch.

9.0 References

Not applicable

10.0 Enquiries

Director, Service & Business Support
Department of Health and Wellness
PO Box 488
Halifax, NS
B3J 2R8
Phone: (902) 424-6985

11.0 Appendices

Appendix A - Basic and Optional Services

APPENDIX A

Basic and Optional Services

Part A - Basic Services

Each long term care facility resident pays an accommodation charge that is authorized by the Department of Health and Wellness. The following is a list of the basic services that a long term care facility provides at no additional charge to the resident. These services are available to meet the basic requirements of the resident. This list does not necessarily constitute a complete inventory of the services available at no additional charge to the resident.

1. Nursing and/or Personal Care -
 - a. Nursing homes - Nursing and personal care on a 24-hour basis, including care given by or under the supervision of a registered nurse, the administration of medication, and assistance with the activities of daily living.
 - b. Residential Care Facilities and Community Based Options - Personal care and/or supervision on a 24-hour basis, including care given by non-registered staff, the administration of medication, and assistance with the activities of daily living.
2. Facility staff shall provide foot care services within their defined scopes of practice and education.
3. Selected common over-the-counter medication and treatment products. (Note: Prescription drugs are the responsibility of the resident. Residents may be eligible for Nova Scotia Pharmacare benefits).
4. Safety-engineered insulin syringes for residents who are insulin dependent diabetics.
5. Residents may continue to have their personal physician provide care to them in the facility. (Note: Charges for services that are not covered under Medical Services Insurance, MSI are the responsibility of the resident).
6. Supplies and equipment necessary for the care of residents, including the management of skin care, the management of incontinence, and standard precautions for infection control.
7. Supplies and equipment for personal hygiene and grooming, including skin care products, shampoos, soaps, toothpaste, toothbrushes, denture cups, toilet tissue, and facial tissue.
8. Equipment for the general use of residents, including portering wheelchairs, geriatric chairs, walkers, mechanical lifts, shower chairs, and raised toilet seats. This does not include items that are individualized for a specific resident.

9. Meal services and meals, including three meals daily, afternoon and bedtime snacks, therapeutic diets, dietary supplements, and when prior approved by the Department of Health and Wellness, specialized formula, supplies, and equipment required for tube feeding.
10. Social, recreational, and physical activities and programs, including the related supplies, equipment and staff.
11. Laundry, including labeling and machine washing and drying of personal clothes.
12. Bedding and linen, including mattresses, pillows, bed linen, wash cloths and towels.
13. Bedroom furnishings, including beds, bedside tables, chairs, drawers and wardrobes or closets.
14. Standard ward, semi-private, or private accommodation with or without private washroom. Facilities that have private or semi-private rooms/washrooms are prohibited from charging extra, and assign such rooms based on resident care need first.
15. The housekeeping and maintenance of accommodations.
16. Suitable space both indoors and outdoors for the relaxation of residents, and for resident council meetings.
17. Resident trust account services

Part B - Optional Services

Long term care facilities are permitted to charge residents for optional services that do not form part of the services that are included as basic services. Residents must have choice of either using an optional service that is offered by a facility, or making alternative arrangements for themselves

Facilities must provide a full and clear explanation of services for which the resident cannot be charged and a fee schedule for optional services. This document must be provided to the resident/authorized representative at admission and at any time the schedule changes. Optional services may include but are not limited to:

1. Hairdressing/barbering
2. Dry cleaning
3. Telephone service in a resident's room
4. Tax return preparation
5. Transportation services
6. Purchase of internet or television services.

Nova Scotia Department of Health and Wellness Continuing Care Branch

Subject: **Facility Placement Policy**

Original Approved Date: March 28, 2002

Revised Date: January 24, 2011

Original signed by Keith Menzies

Approved By: _____
Keith Menzies, Executive Director, Continuing Care Branch

1.0 POLICY STATEMENT

The Nova Scotia Department of Health and Wellness (DOHW) is committed to providing fair, consistent and appropriate placement to the Long Term Care facilities that fall within the Department's mandate. The Department of Health and Wellness supports the objectives of the Facility Placement Policy within the framework of the Single Entry Access (SEA) Case Management Model.¹

2.0 APPLICATION OF POLICY

The *Facility Placement Policy* applies to long term care facilities under the mandate of the Department of Health and Wellness participating in SEA.

Long term care facilities under the Department of Health and Wellness's mandate include:

- Licensed Nursing Homes or Homes for the Aged (hereinafter referred to as “nursing homes”);
- Licensed Residential Care Facilities (RCF); and
- Community Based Options (CBO) - Small Options and Community Residences.

The *Facility Placement Policy* **does not apply** to long term care facilities under the jurisdiction of the Department of Community Services or to Designated Veterans Affairs Canada (VAC) beds in Nova Scotia long term care facilities. Veterans who apply for admission to non-VAC beds in Nova Scotia's long term care facilities are subject to the long term care Facility Placement Policy.

¹ Refer to the Department of Health SEA Case Management Model Manual February 1, 2002

3.0 PLACEMENT DECISIONS

3.1 Authority

The authority for reviewing and approving or declining applications for admission to Department of Health and Wellness long term care facilities shall rest with the Classification Officers, Department of Health and Wellness, Continuing Care Branch.

3.2 Key Responsibilities of the Classification Officer

- To ensure that all appropriate non-facility options have been exhausted before facility admission is considered and/or approved;
- To facilitate fairness and consistency in facility placement decisions;
- To request additional/specialized assessments be conducted on applicants where indicated and necessary to make the most appropriate service plan decision;
- To make a “Care Level Decision”, ensuring that only those applicants who are determined to be eligible, as per provincial law or policy, are approved for admission to long term care facilities.

3.3 Placement Coordinator

The Placement Coordinator shall:

- Confirm that the client application is complete (i.e., there is a Care Level Decision and an accommodation rate) before placing the applicant on the wait list.
- Co-ordinate approved facility admissions with the applicant and facility;
- Manage the wait list on behalf of the Continuing Care Branch, Department of Health and Wellness; and
- Advise Care Coordinator when applicants are estimated to be within 90 days of placement.

3.4 The Care Coordinator

The Care Coordinator shall:

- Identify suitable applicants for long term care facility placement through the administration of a comprehensive assessment tool;
- Inform applicants of their responsibilities in the application process, including the financial application process;
- Record the applicant’s preferred facility and inform the applicant of the *Facility Placement Policy* and process, including the administrative review mechanism;
- Confirm that care components of the application are complete, before bringing the application forward for eligibility determination.
- Bring placement recommendations to the Classification Officer for decision;

- Notify the Classification Officer of changes in status of applicants when such changes could lead to a change in the Classification Officer's decision.
- Coordinate home care and other non-facility services, including referrals to other services not offered through the Continuing Care Branch;
- Encourage applicant to contact/tour preferred facility and obtain additional facility specific information;
- Conduct reassessments for applicants on the waiting list, within 90 days prior to estimated admission to a long term care facility, and/or when there is a significant change in the applicant's condition or status; and
- Inform applicants of their responsibility to complete the Medical Status Report within 90 days prior to admission to a long term care facility.

4.0 WAIT LIST MANAGEMENT

4.1 Role of Placement Coordinator

On behalf of Continuing Care, the Placement Coordinator shall organize and manage the wait list for long term care placement according to predetermined criteria.

4.2 Entry to the Wait List

Except for Adults in Need of Protection, only fully eligible applicants shall have their names entered on the wait list. Fully eligible applicants include:

- a) persons deemed eligible by a Classification Officer and who have agreed to financially contribute to their care as per the terms outlined by the Department of Health and Wellness.
- b) existing residents, whose eligibility has been previously determined and, who have requested an inter-facility transfer (e.g., nursing home to nursing home).

Adults in Need of Protection may be approved and placed on the wait list by the Placement Coordinator prior to completion of the full assessment process or "Care Level Decision". The placement eligibility for these Adults in Need of Protection may be determined on a post-admission basis.

4.3 First Available Bed Provision

The guiding principle of the First Available Bed Provision is that the care needs of the applicant shall be addressed first and his or her placement preferences shall be pursued second.

For an applicant/resident who is subject to the First Available Bed provision, his or her name will be placed on the wait lists of all long term care facilities that are "suitable" to meet the applicant's care needs and that are within approximately 100 kilometers driving

distance from their "preferred community of residence". An applicant may request to be put on the waiting lists of suitable facilities beyond 100 kilometers of his or her "preferred community of residence".

A "suitable" placement is the offer of a long term care facility bed to an applicant where the characteristics of the available bed are matched to the care needs of the applicant, by the Placement Coordinator.

A "preferred community of residence" may be the applicant's current home community or another Nova Scotia community where the applicant prefers to live. For large amalgamated municipalities, such as the Cape Breton Regional Municipality, the preferred community of residence will be documented as the person's community within the larger Municipality (e.g. Glace Bay).

The First Available Bed Provision **applies** to any person who is:

- An Adult in Need of Protection awaiting placement. *Provincial legislation authorizes the placement of these clients in any available and appropriate facility in the province;*
- Placed in a facility as an Adult in Need of Protection or Community Variance which was outside 100 kilometers from their preferred community of residence;
- A medically discharged hospital patient awaiting placement;
- An existing resident of a Department of Health and Wellness long term care facility (currently residing in the facility or a hospital) who is reassessed as needing a different level of care that must be met at another Department of Health and Wellness licensed/approved long term care facility; and
- An existing resident of a Department of Community Services facility/community based option program, which includes Regional Rehabilitation Centers, Adult Residential Centers, Residential Care Facilities, Group Homes, Developmental Residences, Small Option Homes, and Alternative Family Support Homes. The resident must also be reassessed as needing a different level of care that can only be safely met at a Department of Health and Wellness licensed/approved long term care facility.

The First Available Bed Provision **does not apply** to an individual who is:

- A client living at home in the community and awaiting placement;
- An existing resident of a long term care facility who is seeking an inter-facility transfer to a similar long term care facility (i.e. nursing home to nursing home);
- An applicant returning "home" to their Long Term Care Facility after an extended hospital stay.
- An applicant requiring a different level of care that can be met at the same Long Term Care Site, except in cases where safety is a serious concern.
- An applicant whose family member is a resident of a Long Term Care Facility.
- An applicant requiring Peritoneal Dialysis.

- Applicant who is transferring out of Peter's Place or Aiseirigh House.

Exception to the First Available Bed Provision

Exceptions to the first available bed provision may be considered on a case by case basis where there are compelling circumstances and evidence of a significant impact on client care. The Director, Service and Business Support or designate will review and make decisions on requests for exceptions.

Individuals who are living at home in the community may wish to place their name on several facility wait lists or voluntarily subject themselves to the First Available Bed provision to expedite their placement.

4.4 Applicant's Preferences

At the time of assessment applicants shall be asked to indicate a preferred community of residence and to name one or more facilities to which they prefer to be admitted. Applicants shall be advised that they may change their stated preferences by contacting their Care Coordinator, who will then notify the Placement Coordinator on the clients' behalf.

The Placement Coordinator shall advise the Care Coordinator if the applicant has chosen a facility which cannot meet the identified care needs.

The applicant's preferences shall be recorded in the wait list management system. Where an applicant's preferred community of residence and preferred facility are outside the boundaries of the District in which he or she resides, the Placement Coordinator shall coordinate the placement with the preferred District.

If the applicant accepts a placement in a facility that is not their first choice, the applicant's name will remain on the wait list until they reach their preferred facility or until the applicant indicates to Continuing Care that they wish to remain at the facility.

A resident of a long term care facility may apply for an inter-facility request at any time. The resident will be entered on the wait list for the requested facility according to the date of the request.

4.5 Refusal and Deferral of a Placement Offer

Applicants shall have the right to refuse any offer of placement. Applicants who are subject to the First Available Bed provision and subsequently refuse to accept a "suitable" placement offer, shall have their names removed from the wait list. Applicants who are removed from the wait list may reapply at a later date.

Applicants waiting in the community, who voluntarily have their names placed on a facility's wait list may consider one of three options when they receive a placement offer:

1. Acceptance of placement offer;
2. Deferral for 90 days; or
3. Refusal of placement offer.

Under the deferral option, applicants can decide to temporarily remove their names from the Long Term Care wait list for a maximum of 90 days from the deferral decision date. Applicants can have their names reactivated on the wait list at their original care level decision date at any time within the 90 day period. Immediately following the end of the 90 day period, applicants' names will be reactivated on the wait list. Applicants will only be allowed to defer placement once, if an applicant refuses a second placement offer, the applicant will be removed from the wait list and may reapply at a later date. Applicants who choose to refuse the first placement offer will also be removed from the wait list and may reapply at a later date.

When an individual reapplies, the Care Coordinator will discuss the application process with the person to ensure that the individual understands that the application should only be made when the individual is prepared to accept a suitable placement offer.

4.6 Wait List Organization Criteria

The wait list shall be organized and managed in accordance with the following priority rankings. All first priority applicants will be placed before second priority applicants and second priority applicants before third priority applicants.

Priority 1

Adults in Need of Protection. These applicants:

- have been assessed by Adult Protection and have been determined to meet the criteria of an Adult in Need of Protection according to the *Adult Protection Act*.

If there is more than one Priority 1 applicant at any given time, they shall be organized on the wait list according to the urgency of need.

In the event an Adult in Need of Protection is placed in a facility outside 100 kilometers driving distance from their preferred community of residence, they will become a Priority 2 client until they are placed within approximately 100 kilometers driving distance from their preferred community of residence. After the client is placed within 100 kilometers from their preferred community of residence, their priority status will change to a Priority 3.

Priority 2

The following eight types of applicants are deemed to be Priority 2 status for placement:

Client Returning "home" to their Long Term Care Facility - The applicant:

- was a resident of a long term care facility who lost their bed, due to an extended hospital stay;
- is ready for hospital discharge and wishes to return to their original long term care facility; and
- has been assessed by Continuing Care to have a care level consistent with that provided by the applicant's preferred facility.

Applicant Requiring a Different Level of Care that can be met at the same Long Term Care Site (i.e., facility has both nursing home and residential care level beds)

- requires a different level of care that can be met by admission to another level of care located on the same site;
- wishes to continue living at the same site;
- has been assessed by Continuing Care to have a care level consistent with that provided by the applicant's preferred facility; and

In cases where safety is a serious concern, the First Available Bed Provision may be applied to residents in these facilities.

Applicant Requiring a Different Level of Care that can not be met at the same Long Term Care Site –The applicant:

- is an existing resident of a Department of Health and Wellness long term care facility (currently residing in the facility or a hospital); and
- has been reassessed as requiring a different level of care that can only be met at another Department of Health and Wellness licensed/approved long term care facility.

OR

- is an existing resident of a Department of Community Services facility/community based option program, which includes Regional Rehabilitation Centers, Adult Residential Centers, Residential Care Facilities, Group Homes, Developmental Residences, Small Option Homes, and Alternative Family Support Homes.
- resident may be currently residing in the facility/community based option program or a hospital; and
- has been reassessed as requiring a different level of care that can only be safely met at a Department of Health and Wellness licensed/approved long term care facility.

Applicant whose Family Member is a Resident of a Long Term Care Facility - The applicant:

- has a spouse, parent, sibling or dependent child who is living in a DOHW long term care facility;
- wants to live in the same location as the family member; and
- has been assessed by Continuing Care to have a care level consistent with that provided by the facility in which the family member resides.

Applicant Requiring Peritoneal Dialysis - The applicant:

- requires placement in a facility that has specially trained staff, an appropriate staffing complement and the physical environment to support the provision of peritoneal dialysis care.

Applicant who is transferring out of one of the following two facilities:

- Peter's Place
- Aiseirigh House

Applicants with an Approved Community Variance Request – The applicant:

- see Section 4.8 for more information

Client moving from a DOHW facility outside 100km of the client's preferred community of residence to a DOHW facility within 100km of a client's preferred community of residence.

- Applies to only clients placed through Community Variance or Adults in Need of Protection

With the exception of applicants with an approved Community Variance Request, Priority 2 applicants are organized on the wait list in chronological order in accordance with their "Care Level Decision" dates.

Priority 3

The following three types of applicants are deemed to be Priority 3 status for placement:

Applicant Waiting in the Community - The applicant:

- has been assessed by Continuing Care to have a care level consistent with that provided by a DOHW long term care facility; and
- is temporarily manageable in their current setting due to the presence of family supports or other system resources.

Applicant Waiting in Hospital - The applicant:

- has been medically discharged and cannot return home to the community with non-facility based Continuing Care services; and
- has been assessed by Continuing Care to have a care level consistent with that provided by a DOHW long term care facility.

Applicant Waiting for Transfer in a Long Term Care Facility - The applicant:

- is currently residing in a DOHW long term care facility; and
- has requested a transfer to another DOHW approved or licensed long term care facility which will provide the same level of care; and
- the client does not have outstanding bad debt in the facility in which they currently reside.

Priority 3 applicants are organized on the wait list in chronological order in accordance with their “Care Level Decision” dates, except as follows:

- applicants who are removed from the wait list, and subsequently reapply, are listed on the wait list system according to their most recent “Care Level Decision” date;
- residents who request a transfer to another DOHW facility after they have been placed, are positioned on the wait list according to the date that the Placement Coordinator is informed of the resident’s transfer request;
- applicants who have received a “Care Level Decision” and subsequently become acutely ill, will not be considered for long term care placement or transferred until they are medically stable, have been reassessed, and, if warranted, undergo an eligibility review by a Classification Officer. If after the reassessment/review the applicant is deemed eligible, the original “Care Level Decision” date will be used as the wait list reference date.

4.7 Variance to the Wait List Ordering System - Applicants in Hospital

In exceptional circumstances, where a hospital in a District is unable to meet accepted standards of service provision because of a shortage of beds, application may be made to the Director, Service & Business Support for a temporary variance from the Continuing Care wait list policy.

This variance may be used to increase the priority ranking of long term care facility applicants waiting in the hospital. The rank order of applicants may be increased within the Priority 3 category, but they shall not be given a higher priority than existing Priority 1 and Priority 2 applicants.

4.8 Variance to the Wait List Ordering System - Applicants in Community

In exceptional circumstances, where an applicant is deemed to be in a high risk situation and his/her support system and District Health Authority have demonstrated reasonable effort to meet the needs of the applicant in the community, an application may be made to the Director, Service & Business Support or designate for a needs-based variance from the long term care wait list policy.

This variance may be used to increase the priority ranking of applicants waiting in the community. The rank order of applicants may be increased from Priority 3 to Priority 2, but they shall not be given a higher priority than existing Priority 1 applicants.

If a Community Variance is granted, the applicant and/or substitute decision maker should understand that the criteria for placement ahead of others *are based on risk*; preference is secondary. Therefore, clients will have Priority 2 status for placement and be put on the wait list for all “suitable” facilities in Nova Scotia. In the event the applicant is placed in a facility outside 100 kilometers driving distance from their preferred community of residence, they will remain a Priority 2 client until they are placed within approximately 100 kilometers driving distance from their preferred community of residence. After the client is placed within 100 kilometers from their preferred community of residence, their priority status will change to a Priority 3 as they await a transfer to their preferred facility.

Requests may be submitted using the Department of Health and Wellness Community Variance Request Form.

4.9 Adults in Need of Protection Placed Prior to Care Level Decision

The Placement Coordinator may place an Adult in Need of Protection prior to completion of the “Care Level Decision” from a Classification Officer. In these instances, a “Care Level Decision” shall be obtained post admission. These residents must also undergo the financial assessment process after they have been safely admitted to a facility.

4.10 Inter & Intra-Facility Nursing Home Transfers

Inter-facility transfer requests from residents who were admitted to a long term care facility before the advent of the long term care Facility Placement Policy or the policy of "Universal Classification" (February, 2001) and who have not undergone the full care level and financial assessment and eligibility processes must undergo the assessment and eligibility process before being placed on the wait list.

For residents who are transferring between facilities and who have already had a financial and a care assessment, the assessment and eligibility determination do not need to be conducted again unless the level of care has changed and the admitting facility is operating under an approved per diem schedule that varies by care level.

The assessment and eligibility determination processes are not required for residents who move within a home or for residents who return to their "held" bed in a facility after a stay at hospital, unless the level of care has changed and the home has Department of Health and Wellness designated Level 1 or Level 2 beds.

Long term care residents who lose their bed due to an extended stay in a hospital must undergo a care assessment and eligibility process before being placed in a facility.

4.11 Placement to Licensed Respite Beds

See *Facility Based Respite Policy* in the Continuing Care Long Term Care Policy Manual.

4.12 Placement to Residential Care Facilities (RCF)

Due to the distribution of RCF facilities across the province, some applicants will not have access to a RCF within 100 kilometers one-way driving distance of their home or preferred community of residence. Under certain conditions these applicants may be admitted to a nursing home.

Under the following exceptional circumstances, an applicant who has been approved for RCF placement, may be wait listed for or admitted to a nursing home.

Applicant Waiting in the Community:

- there are no DOHW licensed RCFs within 100 kilometers driving distance of the applicant's preferred community of residence.
- nursing homes with designated level 1 beds must be accessed if available within 100 kilometers of the applicant's preferred community of residence. In the absence of level 1 beds, applicants can be wait listed for level 2 beds.

Applicant Waiting Placement in Hospital:

- every effort has been made to discharge the client home with appropriate home care and other community based supports.
- where hospital discharge is not possible, the applicant shall be required to put their name on the waiting lists of all suitable DOHW licensed RCFs that are within 100 kilometers driving distance of the applicant's preferred community of residence.

- where there are no DOHW licensed RCFs within the 100 kilometers, the applicant may be wait listed for nursing homes.
- nursing homes with designated level 1 beds must be accessed if available within 100 kilometers of the applicant's preferred community of residence. In the absence of level 1 beds, applicants can be wait listed for level 2 beds.

4.13 Out of Province Applications

See *Service Eligibility Policy* in the Continuing Care Long Term Care Policy Manual.

5.0 FACILITY ADMISSION PROCESS

5.1 Notification of Vacancy by Facility

The facility shall inform the Placement Coordinator of each vacancy by indicating the specifications of the vacancy, including but not limited to: private/semi/ward room, gender of roommate if applicable, etc. Regular bed vacancies are reported on the "Notice of Vacancy" form. Respite bed vacancies are reported on the "Respite Stay Admission Notification" form.

5.2 Response to Notification of Vacancy

Upon receipt of the notification of a vacancy, the Placement Coordinator shall send the long term care facility the completed assessment forms and summary of the "Care Level Decision" for the applicant who matches the facility's vacancy specifications and is closest to the top of the wait list for that facility.

5.3 Facility's Choice of Admissions

The facility shall advise the Continuing Care Placement Office of their acceptance or refusal of an application and agree to an admission date, if applicable.

The Department of Health and Wellness shall not normally schedule an admission to a licensed bed in the same day that the bed is vacated. With the agreement of the admitting facility, a booking may occur on the same day the bed is vacated.

The facility shall have the right to refuse an applicant if it can demonstrate that it does not have the resources to meet the applicant's care needs.

The facility shall inform the Placement Coordinator in writing of any decision to refuse placement and list the reasons for the refusal. Upon receipt of the refusal notification, the Placement Coordinator shall send the documentation for the next appropriate applicant on the wait list. The District Manager shall act in accordance with the Refusal Process.

Facilities shall not refuse an applicant on the basis of ethnicity, religion, language, or community of residence.

Facility refusals will be reviewed on a regular basis by the Department of Health and Wellness. Where there are concerns related the use of a facility's "right to refuse", the Department of Health and Wellness shall, in consultation with the facility, review the facility's history of refusals.

Department of Health and Wellness staff person who is responsible for inspecting the facility shall be involved in the review process.

5.4 Applicant Disagreement with Care Level Placement Decision

See *Service Decision Review Policy* in the Long Term Care Facility Policy Manual.

6.0 DISCHARGE OF RESIDENT

In the event a resident wishes to leave a facility in order to reside back in his/her community permanently, the facility, in consultation with a Continuing Care Coordinator and the resident (and/or their substitute decision maker if applicable), must ensure there is an appropriate discharge plan in place to support the resident in the community.

In the event a facility wishes to discharge a resident, the facility, in consultation with a Service Delivery Consultant, Continuing Care Coordinator, and the resident (and/or their substitute decision maker if applicable), must ensure there is an appropriate discharge plan in place to support the resident.

Facilities are responsible to ensure that residents have capacity to make decisions related to their personal care. If there is a reasonable basis to believe that the resident may or does lack the capacity to make this decision, then the facility should respond in accordance with the provisions outlined in the *Personal Directives Act*.

Once a resident is discharged from a facility to community, at a later date he/she may apply again for long term care admission. At that time, he/she will have to be reassessed to determine care needs. The resident will be considered a new admission and have a new care level decision date.

7.0 ACCOUNTABILITY

The Executive Director, Continuing Care Branch is responsible for ensuring compliance with this Policy.

8.0 MONITORING

The implementation, performance, and effectiveness of this Policy will be monitored by the Executive Director, Continuing Care Branch.

9.0 REFERENCES

Community Variance Request Form

10.0 ENQUIRES

Director, Service & Business Support
Department of Health and Wellness
PO Box 488
Halifax, NS
B3J 2R8
Phone: (902) 424-6985

11.0 APPENDICES

Not applicable.

Policy: FACILITY BASED RESPITE POLICY

Approval Date: October 31, 2011

Effective Date: November 1, 2011

Approved by: *Original signed by Kevin McNamara*

Kevin McNamara, Deputy Minister of Health and Wellness

Version Control: Replaces January 24, 2011 version

1.0 INTRODUCTION

- 1.1 Department of Health and Wellness recognizes the important role family and friends serve in the provision of care to individuals living in the community. The following policy was developed to improving access to long term care facilities for the purpose of providing caregiver respite.
- 1.2 The term “caregiver” is used to refer to a family member or friend providing unpaid care and/or support for a person requiring care

2.0 POLICY STATEMENT

- 2.1 The Minister of Health and Wellness licenses long term care facilities to provide respite services for caregivers of eligible care recipients.
- 2.2 The Department and the long term care facilities shall promote the availability of licensed respite beds to potential clients.

3.0 APPLICATION OF THE POLICY

- 3.1 This policy applies to licensed respite beds in long term care facilities (i.e. nursing homes and residential care facilities) that receive funding from the Department of Health and Wellness, and exclusively admit residents referred by the Department of Health and Wellness.

4.0 PURPOSE OF RESPITE BED

4.1 The purpose of a “respite” bed is to provide the caregiver a planned and temporary break from their care giving responsibilities. The break is usually scheduled, but emergency situations where the caregiver is suddenly and temporarily unavailable may be accommodated.

4.2 Respite beds shall not be used:

As holding beds for those seeking “regular bed” admissions. Regular beds means those long term care facility beds that are licensed/approved by the Minister of Health and Wellness for the purpose of providing care and accommodation to individuals who are not expected to be discharged to the community in the short term;

For clients of the Department’s Adult Protection Services. An “adult in need of protection” requiring regular bed placement is managed under the Facility Placement Policy as a “Priority 1” placement; and

As a place to convalesce after an inpatient hospital stay with the exception of those applicants whose caregiver requires relief from their care giving duties and who can agree to a scheduled discharge date.

5.0 APPLICATION PROCESS

5.1 Assessment & Eligibility Determination

5.1.1 Applicants to licensed respite beds must meet the general eligibility provisions found in the Service Eligibility Policy in the *Long Term Care Policy Manual*.

5.1.2 The application for respite care may be made through the toll free intake telephone number 1-800-225-7225. The applicant must undergo a care needs assessment and eligibility determination. The care assessment and eligibility process includes the completion of a RAI-Home Care assessment and a recommendation for a respite bed by a Continuing Care Coordinator. A Medical Status Report will be required within 90 days prior to the respite stay.

5.1.3 Unless there is a change in the person’s condition that warrants reassessment, a person is deemed eligible for facility based respite for one year from the date the respite bed recommendation is made by the Continuing Care Coordinator.

5.2 Facility Based Respite Charge

5.2.1 The “facility per diem rate” is the rate charged to an individual who is covered by a third party payer.

5.2.2 The full “facility per diem rate” is the rate charged to individuals who are:

- provided for by the court or through an award or benefit.

Where a disability necessitating long term care placement is due to an illness or injury and the applicant has received or is pending receipt of a sum of money through a liability award or settlement for future care, the applicant is considered a private payer and is charged the full cost of care and accommodation.

Once the amount identified for future care by the court or through an award or settlement is expended on care, the applicant can apply for a reduced accommodation charge. At the point of financial reassessment, any remaining funds which were awarded for damages other than future care, such as wage loss or for pain and suffering, are considered part of the applicant’s income.

- provided for under any other statute;
- the responsibility of :
 - Veterans Affairs Canada; or
 - the Workers Compensation Board

5.2.3 For Nova Scotians not covered by a third party payer and for status and nonstatus First Nations individuals living on or off Reserve in Nova Scotia, a standard daily respite charge applies. The charge is set by the Department of Health and Wellness and becomes effective on November 1st of each year. The standard daily respite charge is \$33.25 effective November 1, 2011.

5.2.4 The standard daily respite charge is the equivalent value of the maximum Old Age Security and Guaranteed Income Supplement pension for the preceding tax year less the annual “Minimum Retained Income” divided by 365 days. (The Minimum Retained Income is defined in the Resident Charge Policy.)

5.2.5 Applicants with an annual assessed income of less than \$18,786.00 may apply to the Department of Health and Wellness for a reduced daily respite charge by completing the “Long Term Care Facility Financial Application” and undergoing an income test. If eligible, the daily respite charge may be reduced by as much as 50% depending on the applicant’s assessed income level. A description of the application process may be found in the Resident Charge Policy.

5.2.6 Each applicant or their substitute decision maker must sign a District Health Authority *Letter of Understanding - Long Term Care Facility Respite* form prior to admission. (See Appendix A for a template).

5.3 Bookings and Admission

5.3.1 Once an applicant is determined eligible, the District Health Authority shall book the respite stay and coordinate admission arrangements.

5.3.2 Bookings shall be approved on a first come first serve basis of fully eligible applicants.

5.3.3 The District Health Authority shall provide the long term care facility with the completed application and seek acceptance of the booking. With the facility's acceptance, the District Health Authority shall inform the applicant of the confirmed booking including the authorized daily charge and the dates of scheduled admission and discharge.

5.4 Admission Agreement

5.4.1 The Department of Health and Wellness strongly encourages the long term care facility to establish an admission agreement with the resident and their caregiver prior to occupancy.

5.4.2 The admission agreement should contain:

- a description of the service provided,
- the daily rate to be paid and payment terms,
- an acknowledgment that the respite bed admission cannot be converted to a regular bed admission.

5.5 Emergency Respite

5.5.1 Under emergency situations, every effort shall be made to complete the application prior to admission. If necessary, the District Health Authority may permit the admission of an applicant to a long term care facility respite care bed before the application process is concluded.

5.5.2 A situation is considered “Emergency” when all of the following conditions are satisfied:

- there is a sudden and temporary loss of the applicant’s caregiver,
- replacement caregivers are not available, and
- the District Health Authority has determined that the applicant cannot live safely in their own home with normally available home care and other community supports.

5.5.3 The emergency respite bed applicant must be willing to accept the closest available bed.

5.5.4 The emergency respite bed applicant or their authorized representative must agree to complete any outstanding parts of the application immediately after admission to the respite bed.

6.0 ANNUAL USAGE

6.1 A person may occupy a respite bed anywhere in the province for up to a total of sixty days in a calendar year.

6.2 The day of discharge for a respite bed resident is not considered to be a day toward their annual maximum usage of sixty days.

6.3 The maximum allowable continuous length of stay in a respite bed is sixty days, with the exception of cases that fall under Section 6.4.

6.4 A person may not occupy a respite bed for more than a total of thirty days during the period between **July 1 and October 1**.

6.5 A person may not occupy a respite bed for more than a total of sixty days during the period between **November 1 and February 28 of the next calendar year**.

6.6 The Placement Office shall track usage and determine whether an applicant has sufficient unused days before authorizing a booking.

6.7 Additional days, beyond sixty per year, may be approved by the District Health Authority.

7.0 STAY EXTENSIONS

7.1 The District Health Authority and the long term care facility shall take all necessary steps to prevent stay extensions from impacting on access to respite beds by others.

7.2 A respite resident may request through the District Health Authority that their scheduled stay be extended.

- 7.3 The resident's stay extension shall be accommodated if the resident has not fully used their annual sixty days, and another applicant does not book the respite bed.
- 7.4 If a request for a stay extension cannot be accommodated, and if it is not feasible to discharge a resident after they have completed their scheduled respite stay, the resident shall be considered in need of a long term care facility "regular bed". In such cases, the resident is expected to complete the application process for regular bed admission, and to accept the first available regular bed that is offered by the District Health Authority recognizing that the vacancy may not be in the local area.

The resident shall be charged the regular bed Standard Accommodation Charge for each day following the scheduled respite bed discharge date, until the resident or their representative signs the *Notice of Authorized Charge* form. When the resident completes the application and placement process, the resident shall be retroactively reimbursed the difference between the Standard Accommodation Charge and the resident's Notice of Authorized Charge.

8.0 REGULAR BED APPLICANTS

- 8.1 An applicant waiting in the community for a long term care facility "regular bed" admission may apply to use a respite bed, if there is a valid respite need, and it is clear that the applicant's situation can accommodate the scheduled discharge date.

9.0 RESIDENTIAL CARE FACILITY RESPITE BED UNAVAILABLE

- 9.1 The District Health Authority may approve a nursing home respite bed admission, if the applicant meets the eligibility criteria for placement to a residential care facility, and there is no residential care facility respite bed within a 100km of the applicant's community.

10.0 USE OF A LICENSED REGULAR BED FOR A RESPITE STAY

- 10.1 The District Health Authority may approve the use of a long term care facility "regular bed" for the purpose of a respite stay if the regular bed is vacant and expected to be vacant for the period of the proposed respite stay.

11.0 ACCOUNTABILITY

The Executive Director, Continuing Care Branch is responsible for ensuring compliance with this Policy.

12.0 MONITORING

The implementation, performance, and effectiveness of this Policy will be monitored by the Executive Director, Continuing Care Branch.

13.0 REFERENCES

Not applicable.

14.0 ENQUIRIES

Director, Service & Business Support
Department of Health and Wellness
PO Box 488
Halifax, NS
B3J 2R8
Phone: (902) 424-6985

15.0 APPENDICES

Appendix A - Letter of Understanding Template

**LETTER OF UNDERSTANDING (Template)
Long Term Care Facility Respite**

Part A. Identification:

Print name of applicant: _____ HCN#: _____

Part B. Other Coverage:

Is the applicant eligible for funding for the cost of long term care from:

	YES	NO
Veterans Affairs Canada VAC# _____	<input type="checkbox"/>	<input type="checkbox"/>
Workers Compensation Board	<input type="checkbox"/>	<input type="checkbox"/>
Structured Court Settlement as a result of an accident	<input type="checkbox"/>	<input type="checkbox"/>

Part C. Applicant Understanding:

I, the applicant or the applicant's substitute decision maker:

- have had the terms of the Respite Care Program explained to me and I understand that this is not a permanent admission to a Long Term Care Facility and that the applicant will be discharged on the pre-arranged discharge date;
- accept responsibility for non-insured health services and supplies such as clothing, prescription drugs, mobility equipment and transportation costs; and
- if answering "NO" to all of the questions under Part B, agree to guarantee payment of the long term care facility standard daily accommodation charge for respite services **or** the reduced daily respite charge as authorized by the Eligibility Review Unit.
- if answering "YES" to any of the questions under Part B, agree to guarantee payment of the admitting long term care facility's full "per diem rate" at the time of admission.

Signature of Applicant/Substitute Decision Maker

Date

If signed by the Substitute Decision Maker, complete the following:

Print Name - _____

**Nova Scotia Department of Health
Continuing Care Branch**

Subject: Resident Trust Account Policy

Effective Date: January 1, 2005 Revised Date: May 1, 2009

Original Signed by Keith Menzies

Approved By: _____

Keith Menzies, Executive Director,
Continuing Care Branch, Department of Health

1. Introduction

- 1.1. Where possible, a resident's financial arrangements prior to admission should continue, if this is the resident's wish.
- 1.2. Residents should be encouraged to:
 - manage their own assets or personal funds and/or
 - arrange for a system to have their funds managed by their families/authorized representatives or
 - arrange to have their funds managed by a financial institution such as a trust company or bank.
- 1.3. The Office of the Public Trustee may also be contacted as a last option, if the resident's situation meets the criteria for involvement of that office.
- 1.4. The purpose of a resident trust account is for the convenience of residents who need to have funds maintained in a safe place and readily available for use in the long term care facility.

2. Policy Statement

- 2.1. All long term care facilities are required to provide a resident trust account for residents' "personal funds", for those residents who may wish to use this service.
- 2.2. "Personal funds" may include funds from income or from a statutory benefit (e.g. OAS, CPP) and any funds that are deposited by the resident or by the resident's representative for the resident's personal use.

3. Application of the Policy

This policy applies to licensed and approved long term care facilities that are under the mandate of the Department of Health (i.e. nursing homes, residential care facilities, and community based options).

4. Management of Resident Trust Accounts

- 4.1 Residents can voluntarily choose whether to use a resident trust account.
- 4.2 Residents can choose the amount of personal funds they would like to deposit, withdraw, and maintain in the resident trust account.
- 4.3 The long term care facility must establish policies for the management of the resident trust accounts, including but not limited to the following:
 - A system to record authorization for charges that the resident/authorized representative directs the facility to be paid from his/her resident trust account,
 - A separation of staff responsibilities for cash handling and cash recording functions,
 - Posted hours when resident trust account funds are available,
 - Amounts that may be withdrawn in cash, and notice that is required for larger withdrawals, and
 - Records management.
- 4.4 Where the resident/authorized representative requests that the resident's money be deposited in the resident trust account, the administrator shall, prior to making such deposit, require the resident/authorized representative to sign a statement acknowledging that they have read the resident trust account policy and understand it.

5. Records Management

- 5.1. The administrator shall maintain a separate, detailed record for each resident's trust account showing the dates and amounts of all withdrawals and deposits.
- 5.2. Upon request, the administrator shall make available to the resident/authorized representative written receipts for all monies received for deposit in the resident trust account. The resident/authorized representative shall provide the administrator with a written receipt for all monies withdrawn from the account.

- 5.3. A monthly itemized statement of money held by the facility on behalf of the resident, charges made to the resident, and the balance of the account shall be made available to each resident/authorized representative upon request.
- 5.4. Computer records must have back-up records, as required in normal business practice.

6. Complaints

Any complaints from the resident/authorized representative or other person, about the handling or residents' personal funds should be directed to the facility's administrator. If the complaint is not resolved at the facility level, the person may refer the complaint to the Department of Health for investigation.

7. Withdrawals from Resident Trust Accounts

- 7.1. Resident' trust accounts cannot be billed for any charges that are not authorized by the resident/authorized representative in writing.
- 7.2. Each withdrawal from a resident trust account must be authorized in writing by the individual resident/authorized representative. This can be done at the time each withdrawal is requested by the resident/authorized representative, or via a pre-authorized withdrawals agreement for such items as accommodation charges.

8. Charging of Fees for Management of Resident Trust Accounts

There shall be no charge to the resident for resident trust account services.

9. Interest Earned by Residents' Resident Trust Accounts

- 9.1. All resident trust account funds are required to be maintained in an interest-bearing account in a Canadian financial institution that is CDIC (Canadian Deposit Insurance Corporation) insured. The financial institution shall be a bank listed in Schedule I or II of the *Bank Act* (Canada), a credit union under the *Credit Union Act*, or a trust corporation registered under the *Trust and Loan Corporations Act*. The account should:
 - provide the highest interest rate,
 - allow the minimum amount of service charges reasonably available during the period the funds are maintained, and
 - ensure the funds are accessible on short notice without a significant loss of interest.

- 9.2. The resident trust account shall only contain money held for the residents in trust.
- 9.3. If a resident maintains a quarterly balance of more than one thousand dollars (\$1,000.00) in the general resident trust account, disposition of the excess funds should be discussed with the resident or authorized representative. The excess funds should be transferred to a separate interest earning savings account established in the resident's name or elsewhere in accordance with the resident's wishes.
- 9.4. If at any time a resident does not maintain a minimum quarterly balance of one thousand dollars (\$1,000.00) or more, the facility may retain the interest on monies in the general resident trust fund account if the resident or authorized representative is previously advised and understand that this is the policy of the facility. Any interest on monies in the general resident trust fund that are retained by the facility may be used to pay associated bank charges and the residual interest shall be used for the benefit of all the residents in the facility as approved by the Residents' Council.
- 9.5. The administrator shall ensure that, as part of the facility auditor's regular year end procedures regarding resident trust accounts, the auditor verifies that interest earned on trust account balances is allocated in accordance with approved policy of the facility and the Department of Health.

10. Inactive or Closed Accounts

This record shall be retained for at least seven (7) years from the date the resident trust account is closed or becomes inactive.

11. Management of Trust Funds when a Resident is Financially Incapable

- 11.1. On admission, if the resident is capable of granting an Enduring Power of Attorney and if there is a person to whom the resident wishes to grant it, the resident should be encouraged to do so.
- 11.2. If a resident has been managing his/her financial affairs and becomes unable to do so, or when there is concern that a resident may be mentally incapable of managing his/her finances, a number of steps can be taken, as follows:
 - 11.2.1. If there is an Existing Enduring Power of Attorney, the attorney shall:
 - be immediately responsible for managing the resident's financial affairs if the enduring power of attorney document is of the type that is valid immediately upon being signed; or
 - be responsible only after a determination of the resident's capacity has been made (ie. a Certificate of Incapacity completed by the attending physician).
 - 11.2.2. If there is no Enduring Power of Attorney,

- A family member or other appropriate third party may apply to the court to be appointed legal guardian, or in the absence of guardianship order, may assume responsibility for the management of the mentally incapable resident's affairs if they are willing and capable to do so, or
- If there is no family member or other appropriate third party, the Public Trustee may make application to the court to become guardian, or
- In any instance where a family member, an appropriate third party, or the Public Trustee is unable or unwilling to assume responsibility for the management of the mentally incapable resident's financial affairs, the Administrator of the facility in which the resident resides may assume responsibility for managing the residents funds limited to the deposit of funds in the resident trust account and the payment of accommodation charges and items for the resident's personal need or enjoyment. In doing so, the Administrator must act in the best interests of the personal needs of the resident, and must, upon request, provide the Department of Health a documented accounting of the resident trust account including receipts.

12. **Accountability**

The Executive Director, Continuing Care Branch is responsible for ensuring compliance with this Policy.

13. **Monitoring**

The implementation, performance, and effectiveness of this Policy will be monitored by the Executive Director, Continuing Care Branch.

14. **References**

Not applicable.

15. **Enquiries**

Director, Service & Business Support
Department of Health
PO Box 488
Halifax, NS
B3J 2R8
Phone: (902) 424-6985

16. **Appendices**

Not applicable.

NOVA SCOTIA DEPARTMENT OF HEALTH CONTINUING CARE BRANCH

Subject: Specialized Equipment Program Policy

Original Approved Date: January 1, 2005 Revised Date: July 10, 2009

Original Signed by Keith Menzies

Approved by: _____

Keith Menzies, Executive Director, Continuing Care Branch

1.0 POLICY STATEMENT

The Nova Scotia Department of Health (DoH), will provide access to resident specific equipment for eligible residents of long term care facilities under its mandate through a Specialized Equipment Program.

2.0 APPLICATION OF THE POLICY

This policy applies to individuals who are regular bed residents of long term care facilities under the mandate of the Department of Health which exclusively admit individuals referred through the Department of Health's "Single Entry Access" process.

3.0 ADMINISTRATION OF SPECIALIZED EQUIPMENT PROGRAM

The Specialized Equipment Program shall be administered through the Canadian Red Cross, Nova Scotia Region in accordance with the criteria established in the *HELP-Specialized Equipment Program Guidelines*.

4.0 ELIGIBILITY CRITERIA

An individual is eligible to access specialized equipment through the HELP-Specialized Equipment Program when the following criteria have been met:

- is a regular bed resident of a DoH long term care facility;
- requires equipment which is on the Covered Equipment list;
- has been assessed by an Occupational Therapist or Physiotherapist as requiring the specified equipment;
- has the request reviewed and approved by Continuing Care.

5.0 DEFINITIONS

Applicant is a resident of Department of Health long term care who applies for access to specialized equipment through the Continuing Care branch.

Approved Resident is an applicant who has an assessed need for the equipment, meets the program criteria and is approved by Continuing Care to receive specialized equipment through the Specialized Equipment Program.

DoH Long Term Care refers to licensed nursing homes or homes for the aged, licensed residential care facilities, small option homes and community residences (CBO's) which exclusively admit individuals through the Department of Health's "Single Entry Access" process.

HELP-Specialized Equipment Request and Authorization Form is a standard form provided by the Department of Health which is used to request specialized equipment for residents of DoH long term care.

Publicly Assisted resident refers to an applicant who is in a regular bed and who has resided in a long term care facility up to and including December 31, 2004 and received financial assistance from the Department of Health exceeding \$12.75 per day.

Specialized equipment is defined as medical equipment or devices that are used to facilitate and promote resident independence and to improve the quality of care.

6.0 PRINCIPLES OF THE SPECIALIZED EQUIPMENT PROGRAM

The Nova Scotia Department of Health will ensure adherence to the following principles when funding a specialized equipment program:

- **accountability** - the responsibilities of the resident, facility, the Department of Health, and the Red Cross, Nova Scotia Region are clearly communicated;
- **appropriateness** - the specialized equipment provided is relevant to the resident's need, as determined by a professional assessment;
- **consistency** - the specialized equipment is available to DoH long term care residents throughout the province and is provided in accordance with Continuing Care's policies and processes;
- **cost effectiveness** - where available, equipment in the program inventory is used before new equipment is purchased.
- **safety** - the equipment provided is maintained, cleaned and disinfected to reduce or minimize risk for the resident and others.

7.0 COVERED EQUIPMENT

The following is a list of types of specialized equipment that is available through the Specialized Equipment Program to approved residents in DoH long term care facilities:

- specialized mattresses and accessories
- resident specific, specialized bariatric beds;
Note: The Specialized Equipment Program does not provide beds normally funded through the capital equipment process or small equipment budget.
- power and manual wheelchairs, plus accessories
- resident specific specialized transfer aids (e.g, sliding sheets, transfer boards);
- basic positioning chairs;
- customized 2 wheeled walkers with glide tips/skis and rollator walkers, plus accessories
- resident specific slings
- bariatric commodes

The specialized equipment provided will be the minimum required to meet the identified need. Residents choosing alternate or upgraded items are responsible for the full cost of the equipment.

8.0 SPECIALIZED EQUIPMENT FEES

Approved residents may be required to pay a monthly income based fee for the equipment being provided through the Specialized Equipment Program. Fees are based the resident's assessed income used for the purpose of establishing an authorized accommodation charge and the type and quantity of the equipment provided.

The fee charged for specialized equipment is comprised of two elements, a monthly flat rate charge and an amount associated with the particular type of equipment provided. The flat rate charge is a standard amount which is charged to the resident once per month, regardless of the number of pieces of specialized equipment provided. The fee associated with each piece of equipment provided is added to the flat rate charge to determine the monthly specialized equipment fee. Specialized Equipment Program fees will be revised annually.

Specialized equipment fees are determined by the Continuing Care Specialized Equipment Program fee determination process. The fee is collected by the Red Cross. For full information on the determination and application of specialized equipment fees, refer to the *Specialized Equipment Program Guidelines, Appendix V*.

Note: Applicants who are publicly assisted residents of Department of Health long term care are exempt from payment of fees.

9.0 APPLICATION AND APPROVAL PROCESS

Access to equipment through the Specialized Equipment Program is provided in accordance with the application and approval process established by the Department of Health's Continuing Care branch. For a complete description of the process, refer to the following document:

HELP- Specialized Equipment Program Guidelines

Nova Scotia Department of Health

Continuing Care Branch

HELP-Specialized Equipment Program

Guidelines

Date Issued: January 1, 2005
Revision Date: **July 10, 2009**

TABLE OF CONTENTS

SECTION I - INTRODUCTION	3
Introduction.....	3
What is the HELP-Specialized Equipment Program?	3
Definitions	4
Principles of the HELP-Specialized Equipment Program	4
Eligibility	5
Covered Equipment	5
Fees	5
Roles and Responsibilities	6
SECTION II - PROGRAM PROCESSES	9
Assessment for Applicants.....	9
Approval Process	9
Procurement and Provision Process.....	10
Delivery / Set-up Process.....	11
Recycling Process	11
Process for Return or Transfer of Equipment.....	11
SECTION III - FREQUENTLY ASKED QUESTIONS	13
SECTION IV - APPENDICES	17
Appendix I - Red Cross Service Centres	
Appendix II - Specialized Equipment, Request and Authorization Form	
Appendix III - Specialized Equipment, Assessment Form and Guidelines	
Appendix IV - Red Cross Loan Agreement	
Appendix V - Fees	

NOVA SCOTIA DEPARTMENT OF HEALTH CONTINUING CARE BRANCH

HELP-Specialized Equipment Program Guidelines

SECTION I - INTRODUCTION

Introduction

The Nova Scotia Department of Health (DoH), Continuing Care branch will provide access to specialized equipment for residents of long term care (LTC) facilities licensed or approved by the Department of Health.

The Nova Scotia Department of Health has entered into a partnership with the Canadian Red Cross, Nova Scotia Region to provide and recycle specialized equipment to eligible individuals. The Specialized Equipment Program is an adjunct to the community based HELP program and the Bed Loan Program operated by the Canadian Red Cross, Nova Scotia Region.

Access to specialized equipment for eligible individuals will be through the application process established by the Continuing Care branch. Applicants are required to have the need for specialized equipment supported by a professional assessment conducted by a Physiotherapist (PT) or an Occupational Therapist (OT). Approval of requests is the responsibility of the Continuing Care branch. Depending on income, there may be a fee charged to individuals for accessing the specialized equipment.

Specialized equipment shall remain the property of the Red Cross and will be returned to the Red Cross for reuse once it is no longer required by the resident. The Red Cross will be responsible to procure, build to specifications, deliver, set up, maintain and recycle the equipment within the HELP-Specialized Equipment Program inventory.

What is the HELP-Specialized Equipment Program?

The HELP-Specialized Equipment Program is a Department of Health funded service that is available through and administered by the Canadian Red Cross, Nova Scotia Region. Under this program, access to specialized equipment is provide for eligible individuals through an application and approval process which is defined by the Nova Scotia Department of Health and delivered at the District Health Authority level.

Definitions

Applicant means a current regular bed resident of Department of Health licensed or approved long term care who applies for access to specialized equipment through the HELP-Specialized Equipment Program.

Approved Applicant means an individual who has been assessed as having a need for covered equipment, who meets program criteria and who is approved to receive equipment through the HELP-Specialized Equipment Program.

Assessed Income means the income used for the purpose of establishing the applicant's accommodation charge in DoH licensed or approved long term care.

DoH Long Term Care refers to licensed nursing homes or homes for the aged, licensed residential care facilities and approved small option homes and community residences (CBOs), which exclusively admit individuals through the Department of Health's "Single Entry Access" process.

HELP-Specialized Equipment Request and Authorization Form is a standard form provided by the HELP-Specialized Equipment Program which is used to process requests for specialized equipment from applicants.

Publicly assisted resident means an applicant who meets the criteria for a publicly assisted resident as defined in section 6.0 of the Department of Health's *Resident Charge Policy*.

Specialized equipment means equipment or devices that are tailored to a particular individual's needs and that are used to facilitate and promote independence and to improve the quality of care.

Principles of the HELP-Specialized Equipment Program

The NS Department of Health adheres to the following principles when funding a specialized equipment program:

- **accountability** - the responsibilities of the resident, facility, the Department of Health, and the Red Cross, Nova Scotia Region are clearly communicated;
- **appropriateness** - the specialized equipment provided is relevant to the applicant's need, as determined by a professional assessment;
- **consistency** - the specialized equipment is available to eligible applicants throughout the province and is provided in accordance with the policies and processes of the HELP-Specialized Equipment Program;
- **cost effectiveness** - where available, equipment in the program inventory is used before new equipment is purchased.
- **safety** - the equipment provided is maintained, cleaned and disinfected to reduce or minimize risk for the resident and others.

Eligibility

To access equipment through the HELP-Specialized Equipment Program an individual must meet the following criteria:

- is a regular bed resident of a DoH licensed or approved long term care facility; and
- requires equipment which is on the Covered Equipment list; and
- is assessed by an Occupational Therapist or Physiotherapist as requiring the specified equipment; and
- have the request reviewed and approved by Continuing Care.

Specialized equipment is not available through the program for Home Care clients or other individuals not meeting eligibility criteria.

Covered Equipment

The following lists identify the types of specialized equipment available to approved applicants through the HELP-Specialized Equipment Program.

- Specialized mattresses and accessories;
- Resident specific, specialized bariatric beds;
- Power and manual wheelchairs, plus accessories;
- Resident specific specialized transfer aids (i.e.: sliding sheets, trapeze bars);
- Basic positioning chairs;
- Customized 2 wheeled walker with glide tips/skis and rollator walkers, plus accessories;
- Resident specific slings;
- Bariatric commodes.

The specialized equipment provided will be the minimum required to meet the basic identified need. Appropriate substitutions **must be** identified by the prescribing Occupational Therapist and/or Physiotherapist. If no substitutions are listed and/or insufficient rationale is given to support this decision the Red Cross may provide substitutions at its discretion. Residents choosing alternate or upgraded items are responsible for the full cost of the equipment, including labour/maintenance to install upgraded items.

Fees

Approved applicants **may** be required to pay a monthly income based fee for the equipment being provided through the HELP-Specialized Equipment Program.

The Red Cross will invoice the recipient of specialized equipment for any applicable fees on a monthly basis. Payment of applicable fees may be made by cheque made payable to the Canadian Red Cross - HELP, or by pre-authorized Visa, MasterCard, direct debit, or money order.

In the event there is a failure to honour a Fee Agreement and payment to the Canadian Red Cross is in arrears for 120 days, the specialized equipment provided will be recovered at the discretion of the Canadian Red Cross and in accordance with Red Cross procedures.

Note: Applicants who are publicly assisted residents of Department of Health licensed or approved long term care are exempt from payment of fees.

See Appendix V for more information on the determination and application of fees.

Roles and Responsibilities

The following sections provide an overview of the roles, responsibilities and expectations of the various participants and stakeholders in the Specialized Equipment Program processes.

Approved Applicant

- Demonstrates a need for the specialized equipment, which is supported by OT or PT assessment.
- Signs the Red Cross Loan Agreement form acknowledging the conditions of the equipment loan. Where there is no authorized representative designated by the applicant, a representative of the LTC facility may sign on behalf of the applicant.
- Where there is an applicable fee, the applicant or authorized representative, must sign the Fee Record/Agreement form.
- Pay any assessed specialized equipment fees to the Red Cross. Payment may be made by cheque payable to the Canadian Red Cross-HELP or by pre-authorized Visa, MasterCard, direct debit, or money order.
- Responsible for the transfer of specialized equipment when transferring to another Department of Health licensed or approved long term care facility.
- Accept responsibility for loss or damage to the equipment, outside of normal wear and tear.

Prescribing Health Professional

- Provide a professional assessment of the resident, identifying the required specialized equipment and complete a *HELP-Specialized Equipment Assessment Form*, including a manufacturer's order form, two quotes and a Braden scale, if applicable.
- Inform the resident that there may be a monthly fee for equipment provided through the HELP-Specialized Equipment Program.
- Upon delivery of approved specialized equipment, follow up in a timely manner to ensure that the equipment complies with the prescription and is suitable for the resident.
- Provide on-site set up/modifications for recycled equipment.
- Notify the Red Cross upon delivery and set up of equipment for approved resident.
- Inform the resident that Red Cross will be visiting to label the equipment.
- Where applicable, maintain records to ensure that the specialized equipment assigned to a resident remains intact and with that resident until it is no longer required. Alternatively, this function may be the assigned responsibility of a designated LTC staff.
- When requesting in house transfer of equipment to another eligible resident, ensure that the equipment is safe; the equipment has been cleaned and disinfected in compliance with the facility's cleaning and disinfection policies; and that it is set up as appropriate, making any minor adjustments/modifications to meet new recipient's needs. A complete assessment of the new resident receiving the equipment shall be completed and submitted to the continuing care coordinator.

- Where applicable, notify the Red Cross for pick up of equipment, when it is no longer required by the resident. Alternatively, this function may be the assigned responsibility of a designated LTC staff.
- Where applicable, notify the Red Cross if a resident is transferred to another DoH long term care facility. Alternatively, this function may be the assigned responsibility of a designated LTC staff.

Occupational Therapist, Red Cross

- Liaise, as required, with prescribing health professionals, long term care facilities, residents, equipment suppliers, Department of Health staff and District Health Authority staff. This may include assisting continuing care coordinators with fee detail information on requests for complex equipment.
- Review approved specialized equipment requests.
- Arrange for specialized equipment to be provided from HELP-Specialized Equipment Program inventory or through new purchase.
- Ensure completion of the Red Cross *Loan Agreement*, the labeling of purchased equipment and the entry of purchased equipment in the HELP-Specialized Equipment Program inventory.
- Maintain appropriate documentation on the client record.
- Responsible for the ongoing management of the HELP-Specialized Equipment Program.

Long Term Care Facility

- Submit request for specialized equipment, on *HELP-Specialized Equipment Request and Authorization Form*, to Continuing Care on behalf of resident.
- Inform the resident that there may be a monthly fee for the equipment provided through HELP – Specialized Equipment Program.
- Receive specialized equipment and assist with completion of Red Cross *Loan Agreement* documentation. Ensure one copy is placed on the resident’s chart and one copy is held in a designated HELP - Specialized Equipment Program binder.
- Provide routine maintenance, cleaning and disinfection of specialized equipment, regularly **and** before it is returned to the Red Cross or transferred with the resident to another DoH LTC facility.
- Ensure that the specialized equipment assigned to a resident remains intact and with that resident until it is no longer required.
- Maintain records to ensure that the specialized equipment, as provided, is returned to the Red Cross inventory when it is no longer required by the resident for whom it was initially provided.
- If a resident is transferred to another DoH long term care facility, that the equipment is cleaned, disinfected and transferred with the resident and that the Red Cross and the new facility is notified of the equipment transfer. Copies of the Letter of Agreement are to be faxed to Red Cross and new facility.
- Ensure that equipment owned by the Red Cross does not leave the facility if a client is discharged from DoH long term care.

Continuing Care Coordinator

- Receive, review and approve, where appropriate, requests for specialized equipment in accordance with the HELP-Specialized Equipment Program Guidelines.
- Where required, forward requests for specialized equipment to a Supervisor for approval decision.
- Liaise with Supervisor, LTC contact, Red Cross OT, and prescribing OT/PT, as required.
- Assess applicants for Specialized Equipment fee and complete any required documentation.
- Inform approved applicant and/or LTC contact whether the request for specialized equipment is approved or not approved.
- Forward approved requests for specialized equipment and fee agreement form, if applicable to the Red Cross.
- Maintain appropriate documentation on client record.

Continuing Care Supervisor

- Review recommended special equipment requests received from continuing care coordinator for approval, pursuant to the HELP-Specialized Equipment Program Guidelines.
- Notify continuing care coordinator of the approval decision.
- Ensure that appropriate documentation is maintained on the client record.

Red Cross

- Maintain and track an inventory of specialized equipment for use by approved applicants, including the type of equipment, the condition, maintenance schedule, recipient, etc.
- Recycle specialized equipment in whole or in part wherever possible.
- When necessary and as approved, procure specialized equipment for inclusion in the HELP-Specialized Equipment Program inventory in a cost efficient manner.
- Maintain and repair recycled specialized equipment before it is reissued.
- Ensure that all specialized equipment is entered into the inventory and identified for easy retrieval.
- Ensure that Red Cross Loan Agreements are signed by approved applicants or their representatives.
- Comply with the Department of Health, HELP-Specialized Equipment Program Guidelines and any requirements for reporting and evaluation.
- Collect approved HELP-Specialized Equipment Program fees.

Nova Scotia Department of Health

- Provide funding to the Canadian Red Cross, Nova Scotia Region for the operation and management of a program to deliver specialized equipment to eligible recipients.
- Provide direction and guidance through the Specialized Equipment Program Policy and maintenance of the HELP-Specialized Equipment Program Guidelines.
- Ensure applicants are assessed for possible payment of HELP-Specialized Equipment Program fees.
- Ensure processes are in place for review and approval decisions for requests for specialized equipment.
- Provide direction and review of requirements for reporting and evaluation of the HELP-Specialized Equipment Program to the Red Cross, as required.
- Audit the HELP-Specialized Equipment Program for compliance, as required.

SECTION II - PROGRAM PROCESSES

Assessment for Applicants

Any request for equipment through the HELP-Specialized Equipment Program requires an assessment by a health professional. Initial assessments will be completed by an Occupational Therapist or Physiotherapist. Qualified Rehab Assistants or Directors of Care for long term care facilities may submit assessments for repair of Red Cross equipment on behalf of the prescribing therapist. This assessment is to be documented on the *HELP-Specialized Equipment Assessment Form* along with a copy of the Braden Scale, if relevant.

The assessment package must include the recommendation for the specialized equipment along with a detailed prescription, rationale, allowable substitutions, manufacturer's form, two vendor quotes, and Braden scale, if applicable.

The specialized equipment provided will be the minimum required to meet the basic identified need. Appropriate substitutions **must be** identified by an Occupational Therapist and/or Physiotherapist. If no substitutions are listed and/or insufficient rationale is given to support this decision the Red Cross may provide substitutions at their discretion. Residents choosing alternate or upgraded items are responsible for the full cost of the equipment, including labour/maintenance to install upgraded items.

In the event that a resident's physical status changes and new equipment is required to meet the change in need, a new assessment and approval is required.

Approval Process

Applicants to the HELP-Specialized Equipment Program require approval from the Continuing Care for the requested specialized equipment. The approval process includes the following steps:

Step 1

The facility and/or health care professional identify the need for an OT/PT assessment.

Step 2

The facility arranges for an OT/PT assessment for the applicant. The assessment is completed and documented on the *HELP-Specialized Equipment Assessment Form*.

Step 3

The prescribing OT/PT submits the request on the *HELP-Specialized Equipment Request and Authorization Form* to the continuing care coordinator along with the *HELP-Specialized Equipment Assessment Form*, detailed prescription, rationale, substitutions, manufacturer's order form, two vendor quotes, and Braden scale if applicable.

Step 4

Except for requests for specialized beds or mattresses, the continuing care coordinator reviews the request and makes an approval decision. The continuing care coordinator forwards requests for specialized beds or mattresses to the Continuing Care Supervisor for an approval decision. The supervisor will advise the continuing care coordinator of the approval decision.

Step 5

When a request is approved for a fee eligible applicant, the continuing care coordinator visits the applicant to explain the fee and to obtain required documentation. The Red Cross OT may assist with fee detail information on request for complex equipment.

Step 6

The continuing care coordinator notifies the applicant and the prescribing OT/PT of the decision.

Step 7

When a request is approved, the continuing care coordinator forwards the approved authorization, the assessment package and the completed fee agreement letter, where applicable, to the Red Cross for the provision of the specialized equipment.

Equipment Procurement and Provision Process

Once a request for equipment is approved and authorized, it is sent to Red Cross for procurement and provision of the equipment. Whenever possible, the Red Cross will provide the specialized equipment, in whole or in part, from existing inventory. The following describes the steps in the process to provide specialized equipment.

Step 1

The *HELP-Specialized Equipment Request Authorization Form*, assessment package and signed fee agreement letter, if applicable is received by Red Cross.

Step 2

The request and authorization is received and reviewed by the Red Cross Occupational Therapist for processing.

Step 3

The specialized equipment is retrieved from the inventory, or purchased by Red Cross for addition to the inventory.

Step 4

Red Cross notifies the continuing care coordinator, facility, and/or prescribing OT/PT of the status of the equipment request.

Note: Long term care facilities are not to order specialized equipment directly. Inventory is the responsibility of the Red Cross. Facilities are not to perform any repairs without prior approval of Red Cross. Facilities must notify the Red Cross, prescribing therapist, and Continuing Care if any equipment is missing or damaged. The facility is responsible for the cost of replacing missing or damaged equipment.

Delivery & Set-up Process for Specialized Equipment

Once the authorized specialized equipment has been procured, the Red Cross will arrange for its delivery. The following describes the steps in the process for delivery of specialized equipment.

Step 1

The specialized equipment is delivered to the appropriate site.

- Red Cross arranges delivery from existing inventory
- Supplier delivers purchased equipment

Step 2

The specialized equipment is set up and checked by the prescribing Occupational Therapist or Physiotherapist for compliance with the prescription and suitability. OT/PT confirms set up with the Red Cross.

Step 3

Red Cross representative arranges for completion of the Red Cross Loan Agreement and the labeling of equipment. Copies of the Loan Agreement are provided to the recipient and the facility. One copy is to be placed on the recipient's chart and one copy is to be held in a designated HELP – Specialized Equipment binder.

Recycling Process

Red Cross will tag and inventory all specialized equipment purchased for, donated to, or returned to the HELP-Specialized Equipment Program and enter the information in the Specialized Equipment Program database.

Process for Return or Transfer of Equipment

The following describes the processes for return or transfer of specialized equipment.

When the individual is no longer a resident of a facility (discharged or deceased)

- The facility identifies that the specialized equipment is owned by the Red Cross.
- The facility notifies the Red Cross to retrieve the specialized equipment.
- The Red Cross arranges to pick up the equipment and return it to the HELP-Specialized Equipment Program inventory.

Note: The facility is responsible to ensure that equipment owned by the Red Cross does not leave the facility if a client is discharged or transferred to a location other than a DoH long term care facility.

Note: If equipment owned by the Red Cross is transferred to a location other than a DoH licensed or approved long term care facility; the facility must contact the Red Cross immediately. The following process will be implemented to ensure equipment is returned to the Red Cross as soon as possible.

- Red Cross to liaise with all involved parties (e.g. facility representative, care staff, family members) to discuss reasons equipment was removed from facility.
- Red Cross to contact client / family to discuss return of equipment. Information on the Community HELP will be given, to allow family/client to make arrangements for alternative equipment.
- Arrangements will be made to pick up specialized equipment, in accordance with Red Cross procedures.

When a resident is transferred between DoH long term care facilities

- The facility identifies that the specialized equipment is owned by the Red Cross.
- The facility notifies the Red Cross of the resident's transfer and of the name and address of the new facility.
- The originating facility is to notify the new facility of the resident's transfer and to provide a copy of the Red Cross Loan Agreement.
- The originating facility is responsible to ensure that the equipment is cleaned and transferred with the resident.
- A new Red Cross Loan Agreement is to be completed once the resident has relocated.

When the equipment is no longer needed due to change in recipient's health status

- The facility identifies that the specialized equipment is owned by the Red Cross.
- The facility notifies the Red Cross to retrieve the specialized equipment.
- The Red Cross arranges to pick up the equipment and return it to the HELP-Specialized Equipment Program Inventory.

SECTION III - FREQUENTLY ASKED QUESTIONS

1. Who owns the specialized equipment?

The Canadian Red Cross, Nova Scotia Region owns the specialized equipment provided through the HELP-Specialized Equipment Program. Approved applicants will have use of the specialized equipment for as long as needed, as supported by professional assessment and authorized by Continuing Care.

2. Will applicants be able to have a trial period?

The HELP-Specialized Equipment Program will not be providing specialized equipment for a trial period in the facility, unless the equipment is not available locally for a trial and is available in the Red Cross inventory. The continuing care coordinator will provide authorization if a trial from Red Cross is required.

3. Who is responsible to set up the specialized equipment?

For newly purchased equipment, the equipment supplier is responsible for set up. Where the equipment is provided through the HELP-Specialized Equipment Program inventory, the Red Cross is responsible for set up in accordance with the prescribing professional's specifications, prior to delivery. The specialized equipment will be delivered to the prescribing professional, usually the Occupational Therapist. A long term care staff person, e.g. Rehab Assistant, may be designated to accept delivery, where no therapist is available.

The prescribing professional is responsible for the follow-up assessment to ensure that the specialized equipment is safe and suitable for the resident. Once the equipment is properly set up as prescribed, notification is provided to the Red Cross. The facility is responsible to ensure that this is done for the purposes of resident safety.

4. Can unused items be donated to the Red Cross?

It is possible that unused equipment may be donated to the Red Cross for inclusion in the HELP-Specialized Equipment Program inventory. Items suitable for donation will be identified by the Red Cross. Red Cross may purchase used equipment. Such purchases made are at the discretion of the Red Cross OT and in accordance with Red Cross purchasing guidelines.

Facilities are responsible to dispose of any equipment which is unusable or which has been identified by the Red Cross as not suitable for donation.

5. Will batteries be recycled through the Red Cross?

No. However, batteries that still work are to be returned to the Red Cross with the power wheelchair. When required, replacement batteries for equipment provided through the HELP-Specialized Equipment Program are provided through the Red Cross.

6. Will the HELP-Specialized Equipment Program reuse wheelchair cushions?

ROHO's will be recycled. Other cushions, if they are cleanable, will be returned to the Red Cross and recycled. However, products deemed by the Red Cross OT as unfit for recycling due to hygienic reasons will not be accepted.

7. Is there a standard assessment form for health professionals when prescribing equipment?

The HELP-Specialized Equipment Program has developed a standard assessment form that is to be completed by all health professionals who are requesting authorization of specialized equipment. A copy of the *HELP-Specialized Equipment Assessment Form* is found in the appendix section of this document.

8. How will maintenance and repairs to specialized equipment be done?

The long term care facility is responsible for routine maintenance and cleaning of specialized equipment provided through the HELP-Specialized Equipment Program. Requests for repairs outside of routine maintenance will need to be submitted to the continuing care coordinator for approval. Qualified Rehab Assistants or the Director of Care may submit assessments for repair of Red Cross equipment on behalf of the prescribing therapist if there has been no change to the original prescription. If the Occupational Therapist, Physiotherapist, or Rehab Assistant is aware that the equipment is under warranty, he/she will contact the vendor to provide repair or replacement at no cost. Otherwise, the Red Cross will determine if the repair is covered under warranty.

9. Where will the equipment in the Program inventory be stored?

The Red Cross is responsible for storage of the equipment inventory. There are a number of Red Cross service centres across the province. A list of these centres is available in the appendix section of this document. The Red Cross will maintain a database to effectively manage access to the inventory.

10. How will specialized equipment be transported to outlying areas in the province?

The Red Cross will arrange for the most cost effective means to transport specialized equipment.

11. How long will it take to deliver specialized equipment from the Red Cross inventory to the approved resident?

Red Cross will attempt to deliver the specialized equipment as soon as possible to meet the requested need. This will be monitored as the HELP-Specialized Equipment Program evolves and standards are developed.

12. How will the cost-effectiveness of the Specialized Equipment Program be determined?

The Department of Health in partnership with the Red Cross will be evaluating the success of this program.

13. How will Red Cross equipment be identified?

It will be identified by bar codes and Red Cross sticker labels.

14. Must the full assessment form be completed for all assistive devices requests?

Yes, all relevant information must be completed. The continuing care coordinator needs this information to complete the approval process. Incomplete assessment packages will not be approved. The assessment package must include the recommendation for the specialized equipment along with a detailed prescription, rationale, allowable substitutions, manufacturer's order form, two vendor quotes, and a Braden Scale, if applicable.

15. Will the HELP-Specialized Equipment Program provide accessories for equipment not yet part of the program inventory?

Any recyclable assistive device that has been approved will be provided through the HELP-Specialized Equipment Program. If the equipment is resident owned and requires any modification or and/or repairs, ownership of the equipment must transferred to Red Cross **before** the modification/repair will be completed. If resident owned equipment requires substantial additions of removable parts only, Red Cross will purchase the parts, tag them and recover them at a later date. When submitting requests wherein the resident's equipment is to be transferred to Red Cross ownership, a full description of the equipment is required to complete Letter of Agreement.

16. Are individuals with private insurance required to access that coverage for their specialized equipment needs?

Having private insurance does not affect an individual's eligibility to access the specialized equipment provided through the HELP-Specialized Equipment Program. Insurance policies may supplement the services which are available through other programs. DoH long term care residents with private insurance may choose to access this coverage or may be covered by their insurer for any user fee they are required to pay. It is the responsibility of the resident to address any insurance issues.

17. What if the resident wishes to use their insurance but wants the HELP-Specialized Equipment Program to cover a co-pay or deductible amount?

Residents choosing to use their private insurance coverage for equipment are normally responsible to pay any co-pay amount. If the resident elects to complete an agreement which assigns ownership of the equipment to the HELP-Specialized Equipment Program, the Red Cross **may** choose to pay the outstanding amount and will loan the equipment to that particular resident until it is no longer required. Negotiation of this arrangement is a matter between the resident and the Red Cross.

18. Who is responsible for lost or damaged equipment?

The Red Cross manages the HELP-Specialized Equipment Program inventory and will address issues related to lost or damaged equipment with the resident and/or the long term care facility as appropriate. Where a professional assessment deems equipment damage to be beyond normal wear and tear, the long term care facility shall be responsible for replacement or repair of the equipment. This includes replacement of mattress systems and cushions which are not cleaned and disinfected on a regular weekly basis or more as required based on client's level of incontinence. Note: Incontinence products should be utilized when required to ensure the integrity of the specialized equipment is maintained.

19. Who purchases the new equipment when the requested item is not in the HELP-Specialized Equipment Program inventory?

The Red Cross is responsible for the management of the HELP-Specialized Equipment Program. This includes maintenance, repair and reuse of existing equipment items in the inventory as well as arranging for the purchase of new items of specialized equipment when required.

20. Can I transfer equipment in house to another resident after the initial resident user is discharged or deceased?

Possibly. The prescribing therapist must first contact the continuing care coordinator for approval when requesting an in house transfer of equipment. If the request is approved, the prescribing therapist must ensure that the equipment is safe and that it has been cleaned in compliance with the facilities cleaning and disinfection policies. The prescribing therapist is responsible to set up equipment as deemed appropriate, making any small adjustments or modifications to meet the new resident's needs. When submitting a formal assessment, the prescribing therapist must indicate the last known user's name and barcode. If there is no change to the prescription of parts, the therapist is permitted to use the last quotes provided from the initial resident's approved assessment package.

21. Will the Red Cross provide equipment for rehabilitative purposes? E.g.: a walker used for a walking program.

No, the HELP-Specialized Equipment Program provides equipment to meet the basic identified need. Any rehabilitative equipment used for walking programs, etc. are funded through the capital equipment process or small equipment budget.

22. What are the "positioning devices", identified in the fee table as chargeable items?

Positioning devices are used as a component to a seating system in order to maintain functional seating posture and includes: all positioning belts, chest and leg harnesses, drop bases, footboards, foot boxes, specialized armrest pads (e.g.: ottobock) and all trays. Some positioning devices such as elbow stops and/or lateral supports, soft or rigid lateral supports for backrests (excluding lateral supports for gerichairs), all headrests, adductor pads, abductor pads/ pommels, and elevating legrests will be considered a "single charge" positioning device.

23. What is a “single charge” positioning device?

Single charge positioning devices include equipment pieces that can be used in multiples or as a single item, depending on the resident’s need. A single charge will apply if requesting 2 elevating legrests, 2 lateral supports for a backrest, more than one elbow stop, and more than one adductor/abductor pad. E.g., if requesting a tray with 2 elbow stops, the resident will be charged for the tray and one additional positioning device only.

24. Is there a maximum number of “positioning devices” the resident will be charged for?

Yes. The resident will not be charged for more than five positioning devices. E.g., if requesting a seating system with a headrest, a tray with 2 elbow stops (single charge), a positioning belt, a footboard, an adductor pad, and a drop base, the resident will be charged for 5 positioning devices.

25. What is “rehab seating”?

Any custom seating completed by the Nova Scotia Rehab or IWK.

26. What happens if a resident fails to pay the assessed SEP fees?

The Red Cross will use the following process in addressing delinquent fees:

1. When payment has not been received for 60 to 90 days, a phone call will be made by the Red Cross to the resident and/or person who signed Fee Record/Agreement form as the responsible party. Payment arrangement will be made at time of phone call. If extenuating circumstances arise, responsible party is expected to contact the Red Cross for arrangement of payment.
2. If issue is not resolved after 90 days, a letter will be sent to the person responsible for payment.
3. If payment is in arrears after 120 days, a second letter will be sent to make arrangements to pay in full.
4. If at such a time there is no payment, a meeting will be arranged with the appropriate parties (e.g. family members, Red Cross representative, facility representative, etc.) to discuss program policy and fee payment requirements.
5. If failure to honour the fee agreement continues and payments remain in arrears, the equipment provided will be recovered by the Red Cross, at the discretion of the HELP program manager.

Section IV - APPENDICES

Appendix I - Red Cross Service Centres

Appendix II - Specialized Equipment, Request and Authorization Form

Appendix III - Specialized Equipment, Assessment Form and Guidelines

Appendix IV - Red Cross Loan Agreement

Appendix V - Specialized Equipment Fees

APPENDIX I
HEALTH EQUIPMENT LOAN PROGRAM
Red Cross Services Centres

RED CROSS LOCATIONS – NOVA SCOTIA

CENTRAL AREA (DHA 9)

HALIFAX (DHA 9)

Jenn MacNeil (902) 424-1435
Veronique Bourgault (902) 424-1428
(902) 424-1423 (billing enquiries)
Fax (902) 492-0544
133 Troop Avenue
Dartmouth, NS B3B 2A7

NORTHERN AREA

TRURO (DHA 4, 6)

139 Truro Heights Road
Truro Heights, NS B6L 1X2

AMHERST (DHA 5)

16 Church Street, Suite B
Amherst, NS B4N 3A6

WESTERN AREA

KENTVILLE (DHA 3)

10 Pelton Drive
Kentville, NS B4N 3V7

BRIDGEWATER (DHA 1)

Suite 102, 42 Glen Allan Drive
Bridgewater, NS B4V 3N2

YARMOUTH (DHA 2)

341 Highway #1, Dayton Mall
Yarmouth, NS B5A 4A5

EASTERN AREA

SYDNEY (DHA 7, 8)

Raylene Morykot
(902) 564-9564, Fax (902) 564-6752
1140 Upper Prince
Sydney, NS B1P 5P6

Although Red Cross Service Centres exist in each Health District, for the purposes of accessing the HELP-Specialized Equipment Program all enquiries for equipment from Health Districts 1-5 and 9 are processed through the Central District office. Equipment enquiries from Health Districts 6, 7 and 8 are processed through the Sydney office.

APPENDIX II

HELP-SPECIALIZED EQUIPMENT PROGRAM

Request and Authorization Form

HELP Specialized Equipment Program REQUEST AND AUTHORIZATION FORM

DHA: _____

DATE: _____

Care Coordinator		PHONE	FAX
Client Name	FIRST INITIAL LAST HCN	DOB (DD/MM/YYYY)	
Delivery Address (STREET ADDRESS, <u>NOT</u> MAILING ADDRESS)		Contact phone #	
		Facility fax #	
Description of item requested: PLEASE ATTACH ASSESSMENT Rationale:			
Quotes attached: \$ _____ \$ _____			
Signature of the person making the request			YYYY /MM /DD

Recommendation & Comments	For Continuing Care Office Use Only
<input type="checkbox"/> Recommended <input type="checkbox"/> Not Recommended	
_____ Signature (continuing care coordinator)	

Decision	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	<input type="checkbox"/> Monthly HELP User Fee: \$ _____ (Attach Resident Fee Record/Agreement)
_____ Signature & Title		_____ Date

For Red Cross Use Only	
<input type="checkbox"/> Provided from Inventory	
<input type="checkbox"/> Purchased for Inventory	_____ Cost: \$ _____ Supplier

* All fields must be completed or the form will be returned.

APPENDIX III

HELP-SPECIALIZED EQUIPMENT PROGRAM

Specialized Equipment Assessment Form & Guidelines for Completion

HELP-Specialized Equipment Assessment Form

The HELP-Specialized Equipment Assessment Form is not intended to be a comprehensive functional assessment for the purpose of determining a product prescription. Instead it is a summary of pertinent information which supports the need for the equipment request. Health professionals are expected to complete full assessments on residents in order to prescribe the most appropriate equipment.

Use your professional judgment in completing this form.

Part 1A

Identification

Please provide the following information:

- report date
- resident name
- health care number
- date of birth
- gender
- facility where resident is living

Relevant Diagnosis and Associated Conditions

Please list the pertinent medical condition. Include pertinent information on the following items:

Cognitive and perceptual status:

- orientation to time, place, person
- short term and long term memory
- comprehension and insight (include resident's competency and physical ability to complete any required forms. If resident has a user fee and is unable to sign, include Power of Authority contact information).
- attitude and behaviour
- note any hemianopsia or apraxia
- comment on functional hearing and vision

Physical Status:

- weight and height
- pain or discomfort
- edema, location and severity (what measures have been taken to reduce edema)
- range of motion of upper and lower extremities (note contractures or limitations)
- ability to weight shift
- strength - upper and lower extremities
- note any flaccidity or spasticity
- sitting and standing balance - static and dynamic
- endurance

Environmental Factors:

Describe the residents living arrangements as it relates to the prescription and expected pattern of use.

- accessibility (indoor, outdoor terrain)
- safety factors
- existing adaptations
- vocational access
- transportation

Stability of Condition:

Comment on whether the resident's current situation appears to be stable, whether the resident has recently undergone medical treatment or whether condition is thought to be progressive.

Residents Perception of Problem:

Comment on residents own perception of the problem. Are all involved in agreement? Are there any parties who think differently about how the issues should be addressed?

Problem Necessitating Equipment and Therapeutic Benefit Expected

This section describes the reason and benefit of the requested equipment. Include the following information if pertinent.

Functional Status:

Describe the functional level and endurance of the resident affected by the requested equipment. Include the resident's ambulation status, chair propulsion status and method of propulsion, if applicable. Include continence status. If using a wheelchair, indicate number of hours and pattern of use of equipment. How will the equipment impact functional status? What changes is anticipated to occur by the use of the equipment?

Skin Condition:

If the equipment includes pressure relief devices, please describe the resident's current skin condition. Include specific information related to ulcer location, depth, risk, size and length of time ulcer has existed. What other measures have been taken to improve wound healing?

Braden Scale Score:

If the skin condition is a concern, please complete and include a copy of the Braden Scale. See Attachment 2 for a copy of the Braden Scale. Refer to the Nova Scotia Wound Management Protocol for a description of the tool.

Other Considerations:

Use this section to add any additional comments that will help describe the benefits of the requested equipment.

Equipment currently being used, available or tried and reason why not suitable

Comment on any current equipment in use, any trials and/or any equipment available but no longer in use. Explain why such a situation exists. Why the equipment is no longer in use or no longer considered suitable.

Part 1B - Additional Supporting Information and Rationale for request.

Use this section if there is insufficient space in Part 1A to include all pertinent information. Please be clear and concise in your comments. If writing by hand, please ensure document is legible.

Part 2

Equipment Requested

Please include a copy of the manufacturers form if available. This will ensure that the prescription is filled as recommended. Describe the requested equipment in detail and provide rationale for request. The specialized equipment provided will be the minimum required to meet the basic identified need. List all acceptable substitutions. Appropriate substitutions **must be** identified by an Occupational Therapist and/or Physiotherapist. If no substitutions are listed, and insufficient rationale is given to support this decision the Red Cross can provide substitutions at their discretion.

Give further rationale if no substitutions are appropriate. Residents choosing alternate or upgraded items are responsible for the full cost of the equipment, including labour / maintenance to install upgraded items.

Since the program will fill requests with recycled equipment where available, the more detail provided in the equipment specifications, the better chance that the appropriate equipment will be delivered in a timely manner. Include detailed specifications such as hanger degree, seat to floor height to rails, as well as the finished seat to floor height for wheelchair requests. Include the orientation of components, including seat angle (front and rear seat heights), back height and angle, wheel placement (axle position), footplate position, joystick position, power profile settings, position of brakes, positioning devices, etc. Ensure assessment, quotes and manufacturer's order forms are accurate.

Details of special features beyond standard issue

Use this section to provide a rational and description of any equipment considered beyond standard issue. This would include any items such as wheelchair accessories. Be clear in your rational as these items may be considered optional and will not be provided.

Any delivery concerns

Include any concerns with delivery time, date, location. Please include an additional contact name and number for delivery.

Referral Agents Information

Please include the following:

- name of person completing assessment
- professional designation
- signature
- date
- phone number and alternative phone number
- fax number and email address

HELP-Specialized Equipment Assessment Form

PART 1A

Report Date:	HCN #:
Resident Name:	
Date of Birth:	Sex: Male Female
_____ Facility:	
Relevant Diagnosis & Associated Conditions:	
Cognitive Status:	Physical Status: Ht _____ Wt _____
Environmental Factors:	Stability of Condition:
Resident's Perception of Problem to be addressed by equipment request:	
Problem Necessitating Equipment & Therapeutic Benefit Expected:	
Functional Status:	Skin Condition: Braden Scale Score: <i>(include copy)</i>
Other Considerations:	
Equipment Currently Being Used, Available or Tried (RC __ ; other __) and Reason Why Not Suitable:	

Additional Information: Attach Part 1B sheet

PART 1B Additional Information: Resident Name:

HCN#:

Additional Supporting Information and Rationale for Request:

Signature:

Date:

PART 2

Resident Name:

HCN#:

Equipment Requested: *(include copy of manufacturer's order form)* **Acceptable Substitution:** *(list below)***Details of Special Features Beyond Standard Issue:** *(include rationale for need to support additional cost. Add additional sheets if required.)*

Features	Benefits

Any Delivery Concerns:

Name of Assessor:	Signature:
Designation:	Date:
Primary Phone Number:	Fax:
Alternate Phone Number:	Email:

APPENDIX IV

HELP-SPECIALIZED EQUIPMENT PROGRAM

Red Cross Loan Agreement

Canadian Red Cross Loan Agreement

Resident Name

Facility

Health Care Number

Red Cross Loan Number

See page 2 for barcode numbers

Billing Client

You have been authorized to receive a loan of specialized health equipment from the Canadian Red Cross, Nova Scotia Region.

Description of specialized equipment delivered:

Canadian Red Cross Loan Agreement

Resident Name

Facility

Health Care Number

Red Cross Loan Number

Canadian Red Cross Loan Agreement

Resident Name

Facility

Health Care Number

Red Cross Loan Number

Continuing Care has authorized the loan of specialized equipment, as recommended by your health care provider. The Canadian Red Cross Society agrees to loan you this specialized equipment under the following conditions.

1. The specialized equipment has been inspected and has arrived in good condition.
2. The person/facility taking responsibility for the specialized equipment must understand the safe operation of and follow the proper instructions for use of the equipment.
3. If there is a problem with the equipment, the Red Cross will be contacted by telephone at 902-424-1435 / 902-424-1428 / 902-564-9564 or by fax at 902-424-0544 / 902-564-6752.
4. The facility and resident acknowledge that the specialized equipment is loaned on an “as is” basis and that the resident, by accepting the loan of the device, waives any right to claim against the Canadian Red Cross concerning the condition, quality, duration, suitability fitness or operation of the device.
5. The specialized equipment is available to the resident for as s/he requires it. When the equipment is no longer required, it shall be returned to the Red Cross.
6. If the resident transfers to another facility, the Red Cross shall be notified.

Signature of person receiving the specialized equipment

Date

Witnessed by

Date

Agreement Release

- ___ Client no longer needs equipment. (Red Cross to pick up equipment)
- ___ Client deceased. (Red Cross to pick up equipment)
- ___ Client transferred to _____ (New Agreement letter to new facility)

APPENDIX V

HELP-SPECIALIZED EQUIPMENT PROGRAM

FEES

HELP-SPECIALIZED EQUIPMENT PROGRAM FEES

DESCRIPTION

There may be a monthly fee charged to approved applicants for equipment provided through the HELP-Specialized Equipment Program. Fees are based on the applicant's income and the type and quantity of the equipment provided.

The fee charged for specialized equipment is comprised of two elements, a monthly flat rate charge and an amount associated with the particular type of equipment provided. The flat rate charge is a standard amount which is charged to the resident once per month, regardless of the number of pieces of specialized equipment provided. The fee associated with each piece of equipment provided is added to the flat rate charge to determine the monthly specialized equipment fee. The fee is collected by the Red Cross. Payment of fees may be made by cheque payable to the Canadian Red Cross - HELP, or by pre-authorized Visa, MasterCard, direct debit, or money order.

If there is a failure to honour a Fee Agreement and payment to the Canadian Red Cross is in arrears for 120 days, the equipment provided will be recovered by the Red Cross HELP - Specialized Equipment Program, at the discretion of the Canadian Red Cross and in accordance with Red Cross procedures.

FEE EXEMPTIONS

No fees are charged to applicants who fit the following criteria:

- applicants whose assessed income falls within or below a designated income category (see table).
- applicants who are publicly assisted residents of Department of Health licensed or approved long term care.

No fees are charged for the loan of resident specific, specialized bariatric beds.

FEE DETERMINATION PROCESS

1. Continuing care coordinator receives a request on *HELP-Specialized Equipment Request and Authorization Form*. Continuing care coordinator reviews the request and makes an approval decision or forwards the request to a Supervisor, as appropriate.
2. Where the decision is to approve the request, the continuing care coordinator obtains the applicant's assessed income information from the Eligibility Review Unit. If the applicant is required to pay a specialized equipment fee, the Care Coordinator prepares a *Client Fee Record/Agreement* using the HELP-Specialized Equipment Program - Fee Table.

3. The continuing care coordinator visits the resident to explain the fee and to get the *Client Fee Record/Agreement* completed. A copy is provided to the applicant.
4. When the applicant or representative has completed the *Client Fee Record/Agreement*, the continuing care coordinator completes the *HELP-Specialized Equipment Request and Authorization Form*, attaches a copy of the *Client Fee Record/Agreement* and forwards this to the Red Cross.
5. Applicants who choose not to disclose income information shall be deemed to be in the highest Resident Income Category for the purposes of fee determination.



HELP-Specialized Equipment Program

Fee Record/Agreement

Applicant Name: _____ HCN: _____

Your assessed income, as determined through your application for placement in a long term care facility, places you in Resident Income Category: _____.

You are required to pay a fee for the specialized equipment you receive through the HELP-Specialized Equipment Program. You will be billed on a monthly basis.

Payment of fees can be made by cheque payable to the Canadian Red Cross – HELP, or by pre-authorized Visa, MasterCard, direct debit, or money order.

If payment to the Canadian Red Cross is in arrears for 120 days, the equipment provided will be returned to the Red Cross HELP – Specialized Equipment Program.

FEE DETAIL : Details of the monthly fees you are required to pay are provided below.

- 1. Monthly Flat Rate \$ _____
 - 2. Equipment Charge
 - + \$ _____ for _____
 - + \$ _____ for _____
 - + \$ _____ for _____
 - + \$ _____ for _____
 - + \$ _____ for _____
- Monthly Fee = \$ _____

BILLING ADDRESS (include telephone numbers)

Telephone Numbers: _____ (h) _____ (w)

DECLARATION OF RESIDENT OR REPRESENTATIVE

By signing below, I acknowledge my agreement to pay the assessed fees.

Resident/Representative Signature

Date

HELP-Specialized Equipment Program - FEE TABLE

Resident Income Category							
01	02	03	04	05	06	07	08

Income Range:

Low	\$ -	\$ 18,786	\$ 27,179	\$ 35,571	\$ 43,824	\$ 50,076	\$ 56,328	\$ 62,580
High	\$ 18,785	\$ 27,178	\$ 35,570	\$ 43,823	\$ 50,075	\$ 56,327	\$ 62,579	More

Equipment Charge:

Wheelchair - powered	\$ -	\$ 17	\$ 33	\$ 50	\$ 66	\$ 83	\$ 99	\$ 118
Wheelchair - tilt/recline	\$ -	\$ 9	\$ 18	\$ 26	\$ 35	\$ 44	\$ 53	\$ 63
Wheelchair - manual	\$ -	\$ 7	\$ 15	\$ 22	\$ 30	\$ 37	\$ 44	\$ 53
Mattress - L.A.A.L.	\$ -	\$ 18	\$ 35	\$ 53	\$ 70	\$ 88	\$ 105	\$ 125
Mattress - other specialized	\$ -	\$ 9	\$ 18	\$ 26	\$ 35	\$ 44	\$ 53	\$ 63
Mattress overlay	\$ -	\$ 4	\$ 7	\$ 11	\$ 15	\$ 18	\$ 22	\$ 26
Back support - specialized	\$ -	\$ 3	\$ 6	\$ 10	\$ 13	\$ 16	\$ 19	\$ 23
Rehab seating	\$ -	\$ 3	\$ 6	\$ 10	\$ 13	\$ 16	\$ 19	\$ 23
Cushions	\$ -	\$ 2	\$ 3	\$ 5	\$ 6	\$ 8	\$ 10	\$ 11
Rollators	\$ -	\$ 1	\$ 1	\$ 2	\$ 3	\$ 4	\$ 4	\$ 5
Slings	\$ -	\$ 1	\$ 1	\$ 2	\$ 3	\$ 4	\$ 4	\$ 5
Walkers	\$ -	\$ 1	\$ 1	\$ 2	\$ 3	\$ 4	\$ 4	\$ 5
Positioning devices	\$ -	\$ 1	\$ 1	\$ 2	\$ 3	\$ 4	\$ 4	\$ 5
Transfer aids	\$ -	\$ 1	\$ 1	\$ 2	\$ 3	\$ 4	\$ 4	\$ 5
Bariatric commodes	\$ -	\$ 1	\$ 1	\$ 2	\$ 3	\$ 4	\$ 4	\$ 5

Monthly Flat Rate:

\$ -	\$ 16	\$ 16	\$ 16	\$ 16	\$ 16	\$ 16	\$ 16
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NOVA SCOTIA DEPARTMENT OF HEALTH CONTINUING CARE BRANCH

Subject: **Over Cost Fund Policy**

Original Approved Date: January 1, 2005 Revised Date: February 22, 2008

Original signed by Keith Menzies

Approved by: _____
Keith Menzies, Executive Director, Continuing Care Branch

1.0 POLICY STATEMENT

The Department of Health may provide coverage of the cost for the following services or items to eligible residents of long term care facilities under its jurisdiction:

- one-on-one attendant care,
- tube feeds (special diets and related supplies),
- incontinent supplies,
- over the counter medications - *Residential Care Facilities only*
- specialized equipment assessment and follow up visit by an Occupational Therapist or Physiotherapist,
- resident specific supplies (atypical circumstances), and/or
- specified transportation.

2.0 APPLICATION OF THE POLICY

This policy applies to individuals who are regular bed residents of long term care facilities under the mandate of the Department of Health which exclusively admit individuals referred through the Department of Health's "Single Entry Access" process.

3.0 ELIGIBILITY CRITERIA

An individual is eligible to have service costs paid out of the Over Cost Fund when the following criteria have been met:

- The individual is a regular bed resident of a long term care facility, and
- requires a service which is covered benefit under this policy, and
- meets assessment criteria where specified, and
- has the request reviewed and approved by Continuing Care prior to delivery of the service. Retroactive coverage of costs will not be approved.

4.0 CRITERIA FOR AUTHORIZING COVERAGE

4.1 Attendant Care

- May be approved as part of a resident's care plan by a Supervisor or Adult Protection worker for a defined period.
- The resident is assessed by a health professional as requiring one-on-one attendant care due to resident behavioral needs or special care needs.
- Funding will be provided for the most cost effective level of care provider, who can meet the care needs of the resident.
- The long term care facility will provide regular reports of the resident's progress to the Supervisor.
- Attendant care will be monitored regularly by the Supervisor, Care Coordinator or Adult Protection worker, as appropriate.

4.2 Tube Feeds

- May be approved as part of a resident's care plan by a Supervisor.
- The resident requires specialized nutrition through tube feedings based on a completed assessment and recommendation by a registered dietitian.
- The most cost effective and clinically indicated formula and supplies must be selected.
- Funding will be only be considered for costs exceeding the long term care facility's daily raw food costs.
- Authorization may include costs for formulae, bags, tubing and spikes.

4.3 Incontinent Supplies

- The individual is a resident of a RCF or approved CBO under the mandate of the Department of Health.
- May be approved as part of a resident's care plan by a Care Coordinator.
- The resident requires incontinent supplies based on a demonstrated need and supporting documentation.
- The most cost effective supplies must be selected.

4.4 Over the Counter Medications

- The individual is a resident of a Residential Care Facility under the mandate of the Department of Health.
- May be approved as part of a resident's care plan by a Care Coordinator.
- The resident need for over the counter medications is supported by a physician's order.
- The most cost effective items must be selected.

4.5 Specialized Equipment Assessment

- The resident requires a professional assessment/follow up by an Occupational Therapist or a Physiotherapist to determine the requirement for specialized equipment, and
- Occupational Therapy or Physiotherapy services are not provided for in the budget of the facility where the resident lives.

4.6 Resident Specific Supplies

- May be approved as part of a resident's care plan by a Supervisor.
- The resident requires the specific supplies for a demonstrated need which is supported by clinical assessment and documentation.
- The costs of the resident specific supplies is beyond what could be reasonably covered through the facility's nursing budget.
- The most cost effective supplies must be selected.
- The use of resident specific supplies will be monitored regularly by the Supervisor.

4.7 Transportation

- The resident requires transfer from one long term care facility to another as the result of a determination by the Department of Health that a change in the resident's care level necessitates the transfer, or
- The resident requires transfer between long term care facilities when, as a result of the application of the First Available Bed Provision, the resident is placed in a facility which is not the individual's stated first choice at the time of admission and where the resident has not had the cost of an inter-facility transfer covered previously, or
- The resident requires transportation on an ongoing basis between a long term care facility and a hospital for the purposes of hemodialysis treatment or ECT treatment.
- The most cost effective means of transportation must be selected.
- Current ambulance fees are based on rates set by the Department of Health.
- Mileage fees or payment to family members to provide transportation **is not** covered.
- Costs for an escort for the resident during transport are the responsibility of the resident.

5.0 APPLICATION AND APPROVAL PROCESS

5.1 General

- Requests for the coverage of service costs under the Over Cost Fund must be submitted on an *Over Cost Fund Request and Authorization Form*. (See attached)
- As appropriate, the Care Coordinator or Placement Coordination Office will inform the long term care facility of the approval or denial of the request.

5.2 Attendant Care

- A request is submitted to the Care Coordinator who reviews it, makes a recommendation and forwards it to the Supervisor for consideration.
- The Supervisor makes an approval decision and returns it to the Care Coordinator. The Care Coordinator informs the facility of the decision.
- An Adult Protection worker may approve attendant care for Adult Protection clients upon admission to a long term care facility.
- The Adult Protection worker will inform the Supervisor of the approval for attendant care within five (5) working days of making the approval.
- Approval of attendant care is to be documented by the Adult Protection worker on an *Over Cost Fund Request and Authorization Form*. Copies are to be forwarded to the Supervisor and Care Coordinator for inclusion in the client's file.
- Upon receipt of approval, the Administrator or designate will arrange for a care provider to meet the needs of the resident.

5.3 Tube Feeds

- A request is submitted to the Care Coordinator who reviews it, makes a recommendation and forwards it to the Supervisor for consideration.
- The Supervisor makes an approval decision and returns it to the Care Coordinator. The Care Coordinator informs the facility of the decision.
- Requests for coverage of special diets and related supplies must be accompanied by a completed assessment and recommendation from a registered dietitian.

5.4 Incontinent Supplies

- A request is submitted to the Care Coordinator. The Care Coordinator reviews request, contacting facility administrator as necessary to discuss resident's care needs and general condition to ensure that the needs can be met within the RCF/CBO setting.
- Care Coordinator makes approval decision and informs the facility administrator.
- Upon receipt of approval, the Administrator or designate will arrange for the provision of incontinent supplies by the most cost effective means.

5.5 Over the Counter Medications

- A request is submitted to the Care Coordinator.
- Care Coordinator makes approval decision and informs the facility administrator.
- Upon receipt of approval, the Administrator or designate will arrange for the provision of the approved over the counter medications by the most cost effective means.

5.6 Specialized Equipment Assessment

- A request is submitted to the Care Coordinator who reviews it, makes a recommendation and forwards it to the Supervisor for consideration.
- The Supervisor makes an approval decision and returns it to the Care Coordinator. The Care Coordinator informs the facility of the decision.

5.7 Resident Specific Supplies

- A request is submitted to the Care Coordinator who reviews it, makes a recommendation and forwards it to the Supervisor for consideration.
- The Supervisor makes an approval decision and returns it to the Care Coordinator. The Care Coordinator informs the facility of the decision.
- Upon receipt of approval, the Administrator or designate will arrange for the provision of approved resident specific supplies by the most cost effective means.

5.8 Transportation

- Except for coverage of inter-facility transfer costs, requests are submitted to the Care Coordinator for review and approval decision.
- Requests for coverage of inter-facility transfer costs are to be made to the Supervisor of the Placement Coordination Office, or designate.
- Upon receipt of approval, the Administrator or designate will arrange for the resident's transportation by the most cost effective means.

6.0 BILLING FOR APPROVED SERVICES

The long term care facility will invoice the Department of Health for all approved Over Cost Fund charges on a monthly basis in accordance with the procedures established by the DoH - Financial Services.

NOVA SCOTIA DEPARTMENT OF HEALTH CONTINUING CARE BRANCH

Subject: Under 65 - LTC Pharmacare Plan Policy

Effective Date: April 1, 2005 Approved Date: March 4, 2005

Original Signed by Keith Menzies

Approved by: _____
Keith Menzies, Executive Director, Continuing Care Branch

1.0 POLICY STATEMENT

The Department of Health will provide prescription drug coverage as specified in the Nova Scotia Formulary to eligible residents of long term care facilities under its jurisdiction.

2.0 APPLICATION OF THE POLICY

This policy applies to individuals who are under the age of 65 and who are residents of facilities under the mandate of the Department of Health which exclusively admit individuals referred through the Department of Health's "Single Entry Access" process.

3.0 ELIGIBILITY CRITERIA

An individual is eligible to access Pharmacare benefits when the following criteria have been met:

- the individual is a regular bed resident of a long term care facility,
- is under the age of 65,
- has a valid Nova Scotia Health Card Number (HCN),
- does not have access to or coverage under another drug plan, be it from a public or private entity.

4.0 PHARMACARE GUIDELINES

- 4.1 Coverage shall become effective upon admission to a long term care facility.
- 4.2 The unique resident identifier will be the Nova Scotia HCN.
- 4.3 Only those pharmacies who have on-line access to the program administrator for the Pharmacare Programs will be authorized providers for this plan.
- 4.4 The maximum supply of an eligible product to be dispensed at any one time by a pharmacy is in accordance with the Pharmacare tariff agreement.
- 4.5 Coverage will be consistent with the Community Services Pharmacare benefit list in the Nova Scotia Formulary.
- 4.6 Those drugs not listed as benefits in the Nova Scotia Formulary, or drugs not approved for exception status drug coverage, will not be covered.
- 4.7 The program administrator for the Pharmacare Programs shall administer the plan on behalf of the Department of Health.
- 4.8 There will be no resident premium, co-pay or deductible attached to this plan.

5.0 EXCEPTION DRUG STATUS

The *Under 65 Long Term Care Pharmacare Plan* is administered by Department of Health, Pharmaceutical Services through their program administrator. The *Under 65 Long Term Care Pharmacare Plan* follows the Community Services Pharmacare benefit list in the Nova Scotia Formulary. This list provides access to drugs, biological and related preparations, diabetes, and ostomy supplies. Certain drugs are only eligible for coverage when a resident meets criteria developed by the Department of Health, Pharmaceutical Services. These drugs are referred to as “exception status drugs”.

If a resident is being prescribed a drug that has not been approved for exception drug status coverage, the resident should be advised to have their physician request approval through Department of Health, Pharmaceutical Services for coverage.

Approval may be obtained from the Pharmacare Program to cover exception status drugs which are indicated with an ‘FE’ in the benefit status column of the Nova Scotia Formulary. Criteria and request forms are listed in Appendix IV of the Nova Scotia Formulary.

6.0 ENROLLMENT PROCESS

- 6.1 Upon admission of an eligible resident, the long term care facility shall provide written notification to the program administrator for the Pharmacare Programs to enroll the resident in the *Under 65 Long Term Care Pharmacare Plan*. Facsimile notification is acceptable. The following information must be provided by the facility:
- facility name and address
 - name and number for facility contact
 - name of resident
 - resident's date of birth
 - resident's Health Card Number
 - date of admission
 - date of discharge (where applicable)
- 6.2 The program administrator for the Pharmacare Programs will confirm that the resident has a valid Health Card Number and set up the resident as a beneficiary of the *Under 65 Long Term Care Pharmacare Plan*.

7.0 DISCONTINUATION OF ELIGIBILITY

- 7.1 When a resident enrolled in the *Under 65 Long Term Care Pharmacare Plan*, becomes no longer eligible for continued coverage under the plan, the long term care facility shall provide written notification of this to the program administrator for the Pharmacare Programs. Facsimile notification is acceptable. Discontinuation of eligibility may occur for a variety of reasons including, but not limited to:
- discharge
 - transfer to a non DoH facility
 - death
 - age

NOVA SCOTIA DEPARTMENT OF HEALTH CONTINUING CARE BRANCH

Subject: Special Needs Policy - Long Term Care

Original Approved Date: December 22, 2004 Revised Date: December 1, 2008

Original signed by Keith Menzies

Approved by:

Keith Menzies, Executive Director, Continuing Care Branch

1.0 POLICY STATEMENTS

- 1.1 The Department of Health may provide funding of special needs for eligible residents of long term care. Special needs are provided within established frequency, quantity and cost limits. Items or services purchased as a special need will be competitively priced, cost-effective and appropriate for the resident.
- 1.2 A resident's personal resources, above a designated threshold amount, must be applied to the cost of the required item before special needs funding from the Department of Health is available.
- 1.3 Items not specifically referenced or identified in this policy are not available for funding as a special need.

2.0 APPLICATION OF THE POLICY

- 2.1 This policy applies to regular bed residents of Department of Health long term care facilities who were living in a facility as of December 31, 2004 and who were receiving assistance under the Social Assistance Act, and who have chosen to maintain their special needs eligibility.

3.0 GLOSSARY OF TERMS

Assigned maximum value - the maximum amount allowed for a specified item within policy.

Assistive Devices - medical equipment or devices that are basic and essential to facilitate and promote independence and improve the quality of care, as referenced within this policy.

Attendant - a person approved to provide one-on-one staffing as part of a resident's individual care plan. Attendant costs may be available as a benefit under the *Over Cost Fund Policy* and are not provided as a Special Need.

Continuing Care Services - Home Care, Self Managed Care, Long Term Care and Adult Protection services provided by Continuing Care Branch, Nova Scotia Department of Health.

Escort - a person who accompanies a resident to a medical appointment. The provision of an escort can serve to address various needs, including resident safety and communication issues. Resident escort may be provided by facility staff or other appropriate individuals. Escort costs may be provided to publicly assisted residents under the Special Needs Policy.

Fiscal Year - for the purposes of this policy is defined as the 12 month period between April 1st and the following March 31st.

Long Term Care - includes licensed Nursing Homes and Homes for the Aged, licensed Residential Care Facilities, and approved Community Based Options (Small Options and Community Residences) under the mandate of the Department of Health.

Publicly assisted resident - an individual who is in a regular bed and who has resided in a long term care facility up to and including December 31, 2004, and who was receiving financial assistance from the Department of Health exceeding \$12.75 per day and who has not opted to be assessed under the policies in effect as of January 1, 2005.

Resident - is a person who is receiving care in a licensed Nursing Home, Home for the Aged, Residential Care Facility or approved Community Based Option under the mandate of the Department of Health.

Specialized Equipment Program - a program administered by the Red Cross which provides specialized equipment to eligible residents of Department of Health long term care.

Special Needs - are limited to items as defined within this policy.

4.0 POLICY OBJECTIVES

The approval of special needs will be based on the following operational principles:

- 4.1 Special Needs may be provided to supplement the assistance available from the resident's personal resources, informal support network and/or other funding sources.
- 4.2 There is a specific indication that the provision of the special need is required and will benefit the resident.
- 4.3 Continuing Care will fund the most cost effective option available which meets the identified need.
- 4.4 The process for determining eligibility is consistent and equitable.
- 4.5 Cost limits defined in this policy are standardized maximum funding rates allowable for the specified item under the Special Needs Policy.
- 4.6 Residents choosing alternate or upgraded items are responsible for paying any additional costs.
- 4.7 Items available as a benefit through the Over Cost Fund or the Specialized Equipment Program are not provided or funded as a special need.

5.0 ELIGIBILITY CRITERIA

A resident is eligible to apply for special needs funding through this policy under the following criteria:

- 5.1 the individual was residing in a Department of Health facility as of December 31, 2004, is publicly assisted and has chosen to maintain eligibility for special needs, and
- 5.2 the individual does not have the personal resources to cover the cost of the requested special need, and
- 5.3 the individual is not eligible to receive assistance in obtaining the requested special need from any other program or source of funding, such as a private medical or insurance plan, and
- 5.4 there is an identified and documented requirement for the special need.

6.0 RESIDENT CONTRIBUTION REQUIREMENT

- 6.1 Residents are required to apply personal resources, which are above the designated threshold and which are held in the resident's savings or trust accounts, toward the cost of required items.
- 6.2 A resident's personal resources up to the amount of \$1,000.00 are not required to be applied to the cost of an approved item of special need, except in the case of an application for assistance with funeral costs. For funerals, refer to Section 17 of this policy.
- 6.3 Where a resident's personal resources, above the designated threshold amount, are sufficient to cover the cost of the required item, the Department of Health shall not pay for or contribute to the cost of the item.
- 6.4 Where a resident's personal resources, above the designated threshold amount, are not sufficient to cover the full cost of the required item, the Department of Health shall pay as a special need the difference between the resident's personal resources above the designated threshold amount and the total cost of the item.

7.0 APPLICATION AND APPROVAL PROCESS

- 7.1 Requests for special needs must be submitted and approved prior to the purchase or provision of the item requested, unless otherwise stated in this policy. **Retroactive payment or coverage of special needs will not be approved.**
- 7.2 All requests must be submitted to the Care Coordinator on the approved Special Need Request and Authorization Form.
- 7.3 The Care Coordinator reviews the request to ensure it is completed properly and that all required supporting documentation is present.
- 7.4 The Care Coordinator is the approval authority for special needs requests, except where otherwise noted in the policy.
- 7.5 For recurring items, approval may be granted for a period up to one (1) year, unless otherwise stated in this policy.

8.0 APPROVAL OF VARIANCE

8.1 Where there are frequency or quantity limits or an assigned maximum value defined in this policy for specific items and where the approval authority for the requested item is the Care Coordinator, a Supervisor may approve a variance from the defined limit or assigned maximum value, upon application and subject to the following conditions and requirements:

- there is written documentation to support that the maximum allowed for the item of special need is insufficient to cover the requirements in the particular case,
- two quotes for the item must be provided,
- the variance and reasons for this are documented in the client file.

9.0 ATTENDANT CARE

9.1 *Coverage for attendant care is provided to eligible Department of Health long term care residents as a benefit under the Over Cost Fund Policy and is not provided as a special need.*

10.0 CLOTHING/FOOTWEAR ALLOWANCE

10.1 Each eligible resident may apply for a clothing/footwear allowance to a maximum of \$300 per fiscal year.

10.2 Receipts are required for items purchased and must be submitted at the time of billing.

10.3 Unused portions of the allowance cannot be carried forward to the next fiscal year.

11.0 COMPRESSION SLEEVES

11.1 Coverage for the cost of compression sleeves may be approved when there is a physician's order.

11.2 Two quotes must be obtained and submitted with the special needs request.

12.0 COMPRESSION STOCKINGS

12.1 Coverage for the cost of compression stockings may be approved when there is a physician's order. The physician order must identify stocking length and level of compression.

12.2 Approval of compression stockings is subject to the following criteria and conditions:

- the level of compression is 20 mm of mercury or above.
- the resident may be approved for a maximum of two pairs per year, except where there is a change in the level of compression required, as documented by a new assessment and physician's order.
- 2 quotes must be obtained and submitted with the special needs request.

13.0 CO-PAYS ON PRIVATE DRUG PLANS

13.1 Publicly funded residents who access prescription medications through a private medical insurance plan may apply to have co-pay amounts covered as a special need, provided that the medication is a covered benefit under the Nova Scotia Pharmacare Formulary.

14.0 DENTAL SERVICES

14.1 Publicly funded residents may be eligible to receive coverage for emergency dental care, as well as for the cost of dentures.

14.2 Dental coverage will be provided under the following circumstances:

- for the relief of pain;
- for control of prolonged bleeding;
- for treatment of swollen tissue;
- for provision of dentures or repair of broken dentures.

14.3 The cost of an initial examination for the purposes of determining the nature of the problem, any required course of treatment, and the projected cost of the treatment, will be covered without prior approval.

14.4 Dentures will be approved one time only, and will be replaced one time only.

14.5 Dentures shall be obtained by the most economical means. If dentures are provided by a dentist, the dentist must be licensed in the province of Nova Scotia to do so.

14.6 Except for the cost of an initial examination, the cost of dental services will not be reimbursed without prior approval. A detailed statement from the dentist/denturist must accompany the request and should include procedures, codes and fees. Only one quote is required for dental services.

14.7 The cost of dental services will be covered at 100% of the rate published in the current fee guides established by the Nova Scotia Dental Association and the Nova Scotia Denturist Society.

15.0 ESCORTS TO MEDICAL APPOINTMENTS

15.1 Eligible residents may apply for Special Need coverage of the costs for an escort to approved medical appointments. Approved medical appointments include:

- attendance at physician appointment;
- attendance at dentist/denturist appointment
- attendance at an ambulatory care clinic;
- attendance at OT/PT assessment and treatment;
- attendance at diagnostic services.

15.2 The facility is responsible to make arrangements for the most cost effective escort for the resident. No administrative fee may be charged by the facility for arranging this service.

15.3 Coverage of escort costs are provided in accordance with the following criteria:

- there is a demonstrated need for a person to accompany the resident to the medical appointment.
- funding is not provided if the escort is provided by a facility staff person working a scheduled shift on the day of the appointment.
- funding is provided for the actual period of the resident's absence from the facility.

15.4 Escort costs may be approved by the Care Coordinator as a recurring need for a period of up to 12 months..

15.5 Family members are not paid to escort residents to appointments.

15.6 Billing submissions for escort costs must include identification of the resident, a copy of the approval form, level of provider (e.g. CCA, PCW, etc.), duration of escort period and date of occurrence for each transaction billed.

16.0 EQUIPMENT

16.1 *Equipment available as a benefit through the Specialized Equipment Program is not provided as a special need.*

16.2 Covered Equipment

- 16.2.1 Coverage for the costs of positive airway devices (e.g. CPAP, BiPAP) and related supplies may be provided in accordance with the following criteria:
- ▶ the equipment is prescribed by a respirologist or sleep medicine (board certified) specialist in conjunction with a respirologist,
 - ▶ there is a diagnosis of sleep apnea confirmed by one of the following:
 - polysomnography in a sleep laboratory
 - a community based respiratory study
 - oximetry and clinical presentation
 - ▶ two quotes are obtained.
 - ▶ the resident must undergo a trial period with the equipment to determine acceptability and appropriateness of treatment. Costs for the trial are covered as a special need and are to be deducted from the total cost of the equipment, if it is purchased.
 - ▶ approval from a Supervisor is required.
- 16.2.2 Resident specific equipment to meet the unique needs of residents on the Children's Unit.
- 16.2.3 Wheelchair batteries, tires and low-cost items such as arm pads for resident specific equipment that is not provided through the Specialized Equipment Program, may be funded as a special need.

17.0 FUNERALS

POLICY

- 17.1 When a publicly assisted resident dies and does not have sufficient financial resources, or has not made provision to cover funeral expenses, the Department of Health may assist with funeral expenses subject to the terms, conditions and rates contained in this policy.
- 17.2 The Department may assist with the cost of traditional or cremation funeral services. The cost of professional services or merchandise may be paid to the maximum allowable defined in the *Funeral Rates Schedule* incorporated in this policy.
- 17.3 The family or representative of the deceased must make application and demonstrate financial eligibility on behalf of the deceased for all or part of the allowable funeral costs. In the absence of family or a designated alternative, the facility Administrator may act as representative for the deceased.
- 17.4 Application for funeral expenses to be paid for by the Department of Health as a special need **must submitted prior to proceeding with the funeral, or on the first business day following the death of the resident.**

- 17.5 It is the responsibility of the family or representative of the deceased to apply for the Canada Pension Plan Death Benefit. The CPP death benefit amount is to be applied against the maximum allowable funeral costs. In the absence of a family member or representative, the Eligibility Review Unit will apply for the Canada Pension Plan Death.
- 17.6 Funeral arrangements and payment of the client's portion of funeral costs are the responsibility of the individual representing the deceased and the funeral home.
- 17.7 The Department of Health is not responsible for any failure of the family/estate or representative of the deceased to pay the funeral director or any other person/business for funeral related expenses.

PROCESS

- 17.8 The long term care facility will inform the next of kin of the resident's death and make arrangements for the removal of the body to an appropriate funeral home.
- 17.9 The family or representative of the deceased makes a request for assistance with funeral costs. The facility will submit a Special Needs request form on behalf of the family to the Care Coordinator. The facility is to include with the request, complete information on the following:
- the date of death,
 - the balance in the resident's trust or savings accounts, including GST account,
 - excess income in the month of death,
 - the amount of the Canada Pension Plan Death Benefit, if applicable,
 - funeral home price quotation, including the cost break out for services and disbursements.
- 17.10 The Care Coordinator will forward the Special Needs request to the Eligibility Review Unit intake with the supporting information and a copy of the resident's initial financial application and/or case notes as appropriate.
- 17.11 The Eligibility Review Unit will:
- review the application and any supporting documentation, to ensure that all chargeable income, such as private insurance, resident savings and trust accounts, CPP Death benefit amount, excess income in the month of death, etc. is applied against the maximum allowable cost of the funeral;
 - determine the resident's eligibility for funeral coverage and return the signed Special Need request form to the Care Coordinator with an identification of the approved Continuing Care contribution to the funeral costs.
- 17.12 The facility will pay the Department of Health approved amount to the funeral home and bill Continuing Care for the approved amount.

- 17.13 Billing submissions for funeral costs must include: identification of the resident, a copy of the Special Needs approval form, a copy of the funeral home quotation, and a copy of the invoice submitted by the funeral home as per the approved *Funeral Rates Schedule*. The disbursement section will be itemized. The invoice will include professional services and merchandise, disbursements and applicable taxes.

ALLOWABLE COSTS

- 17.14 The total maximum cost for a publicly funded funeral may not exceed the amount established in the *Funeral Rates Schedule*.

- 17.15 Any third party contribution will be applied within the cost limits established in the *Funeral Rates Schedule* and will reduce the Department of Health share of funeral costs accordingly.

17.16 Funeral Rate Schedule

The funeral home may invoice for services and merchandise rendered in accordance with the following schedule of allowable expenses:

1. Professional Services and Merchandise up to a maximum total of \$2,700 plus taxes.
2. Disbursements for one or more of the following, to maximum total of \$1,100 plus taxes:
 - cemetery charges (open, close, clean up grave, burial permits, etc.)
 - grave liner (wooden)
 - crematory fee & return of ashes
 - urns
 - cemetery equipment & set up
 - radio/newspaper notices

 - clothing for the deceased
 - honorariums (clergy, music, etc.)
 - grave lot
3. Mileage over twenty-five kilometres for the funeral coach may be paid on a per kilometre basis at a rate of 60 cents per kilometre, to maximum of \$100.00
4. Any exceptions requested to the approved funeral costs must be approved by the Manager, Eligibility Review Unit.

18.0 HEARING AIDS

- 18.1 A resident may be assisted with the purchase of hearing aids when the need is supported by a hearing assessment. Hearing assessments must be conducted by an Audiologist or a Hearing Instrument Specialist. The hearing assessment must accompany the special need request and authorization form.
- 18.2 Residents may be funded up to a maximum of \$60 to cover the cost of a hearing assessment.
- 18.3 Hearing aids are provided to meet the basic needs of the resident. Continuing Care will fund the cost of the minimum equipment essential to meet the identified need. Residents choosing upgraded items are responsible for paying any additional costs.
- 18.4 Requests to cover the costs of hearing aids must be submitted to the Care Coordinator and approved before purchasing. Two quotes, from separate providers, must be obtained and submitted to the Care Coordinator. If two quotes are not available, an explanation must be provided.
- 18.5 First time users of hearing aids must have a trial period to ensure the hearing aid is effective. The cost of the ear mold and any required deposit will be covered as a special need.
- 18.6 Hearing aid repairs are covered on an as needed basis.
- 18.7 Hearing aid batteries may be approved as a recurring special need.
- 18.8 A hearing aid will be approved one time only, and will be replaced one time only.

19.0 HIP PROTECTORS

- 19.1 Coverage for the costs of hip protectors may be approved when there is a need assessed by an Occupational Therapist, a Physiotherapist or a Registered Nurse.
- 19.2 Approval for two pairs of hip protectors may be considered to a maximum of \$250.00 per year.

20.0 INCONTINENT SUPPLIES

- 20.1 *Funding of incontinent supplies for residents of nursing homes is included in facility budgets and is not provided as a special need. Funding of incontinent supplies for eligible residents of Department of Health Residential Care Facilities and Community Based Options is provided under the Over Cost Fund Policy and is not provided as a special need.*

APPENDIX A



**CONTINUING CARE
SPECIAL NEEDS
Request and Authorization Form**

Category	
<input type="checkbox"/> IHS	<input type="checkbox"/> RCF
<input type="checkbox"/> HOME CARE	<input type="checkbox"/> LTC
<input type="checkbox"/> CBO	

DHA: _____

Date: ____/____/____
DD MM YYYY

Care Coordinator: _____

Phone: _____

Fax: _____

Resident/Client: _____

HCN: _____

Facility/Address: _____

Fax#: _____

DOB: _____

M F

REQUEST FOR: (Description of special need item)

One time only

Recurring
Estimated length of time

RATIONALE:

What other options have been investigated to address this need (i.e. Insurance, etc)

Quotes attached: (if only one, explain) \$_____ \$_____

Assessment Attached: (if applicable) **If Dental, please include fee codes**

AMOUNT REQUESTED: \$ _____	ATTENDANT COST: \$ _____ estimate per month
	Level of Care: _____ # hrs/month: _____
	hourly rate: _____

Signature of person making request: _____

(For Office Use Only) Attach this form to Invoice as proof of approval

Above <input type="checkbox"/> Recommended	Total Amount Approved: \$ _____
Item is: <input type="checkbox"/> Not Recommended	(Approved amount includes taxes)
Recommendation section:	
Care Coordinator Signature: _____	Date: _____
Supervisor Signature: _____	Date: _____
LTC Advisor /Director: _____	Date: _____
Comments: <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved Signature: _____ Date: _____ Title: _____	

- 3.5 “*Original decision maker*” means:
- the Care Coordinator, for service eligibility decisions related to home care or Self Managed Care services; or
 - the Classification Officer, for service eligibility decisions related to long term care facility admission.
- 3.6 “*Reassessment*” means a comprehensive review of the applicant’s situation and care needs through an in-person interview with the client.
- 3.7 “*Review Committee*” means a District Manager of Continuing Care.
- 3.8 “*Review Request*” is the prescribed form for submitting a request for an administrative review of a service eligibility decision.
- 3.9 “*Statement of Reasons for Decision*” means a written statement from the original decision maker containing:
- a statement of the facts on which the original decision was based;
 - a statement of the original decision;
 - a statement of reasons for the decision; and
 - any supporting information reviewed in making the original service eligibility decision.

4.0 Administrative Review

- 4.1 The applicant may request an administrative review of a decision with respect to the following:
- the type of services offered (e.g. home care, residential care facility);
 - the amount of services offered (e.g. hours of home care); or
 - a denial of services requested.
- 4.2 The request for an administrative review must be submitted within 30 days of the date of the applicant receiving the original service eligibility decision.
- 4.3 The request for an administrative review must be made using the approved *Review Request* form and should include the decision for which a review is requested, the grounds for review, supporting arguments and all required information identified on the form.

- 4.4 An administrative review may be requested on the following grounds:
- Error of fact: The decision was based in whole or in part on erroneous or irrelevant facts.
 - Error of policy: The original decision maker failed to follow the relevant policies.
 - Error of law: In the case of long term care service eligibility decisions, the original decision maker failed to follow the relevant provisions of the *Homes for Special Care Act & Regulations*.
- 4.5 The *Review Request* must be sent to the District Manager in the district where the service eligibility decision was made.

5.0 Administrative Review Process

- 5.1 The District Manager shall, upon receipt of a request for administrative review of a service eligibility decision, request a *Statement of Reasons for Decision* from the original decision maker.
- 5.3 The original decision maker shall provide the *Statement of Reasons for Decision* to the District Manager within 10 days of receiving the request.
- 5.4 A copy of the *Statement of Reasons for Decision* shall also be provided to the applicant.
- 5.5 The District Manager shall consider all material provided by the applicant and original decision maker, within the prescribed time limits, to determine whether it is appropriate to forward the request to an Adjudicator.
- 5.6 The District Manager shall decline to refer the review request to adjudication if, after consideration of the submitted material, he or she determines that:
- the application falls outside of the prescribed time limits established by this policy;
 - there are no grounds for an administrative review; or
 - the applicant requires a reassessment, due to a significant change in the applicant's care needs since the original service request.
- 5.7 If, pursuant to section 5.6, the District Manager declines to forward the review request for adjudication, the applicant shall be provided with written notification, giving reasons for the decision.
- 5.8 If the District Manager deems that there are sufficient grounds for an administrative review, the request shall be referred for adjudication to a District Manager in another Continuing Care district. The referral for adjudication shall be made within 21 days of receipt of the *Review Request* form.

- 5.9 The Adjudicator shall conduct the administrative review of the request by examining all written material submitted. There is no in-person hearing.
- 5.10 The Adjudicator may, for the purposes of clarification, request additional information from the applicant and/or the original decision maker. Any additional information provided shall be made available to all parties involved in the review.
- 5.11 The Adjudicator shall provide a written notification of the administrative review decision, including reasons for the decision, to the applicant and to the original decision maker within 14 days of receiving the request from the District Manager.

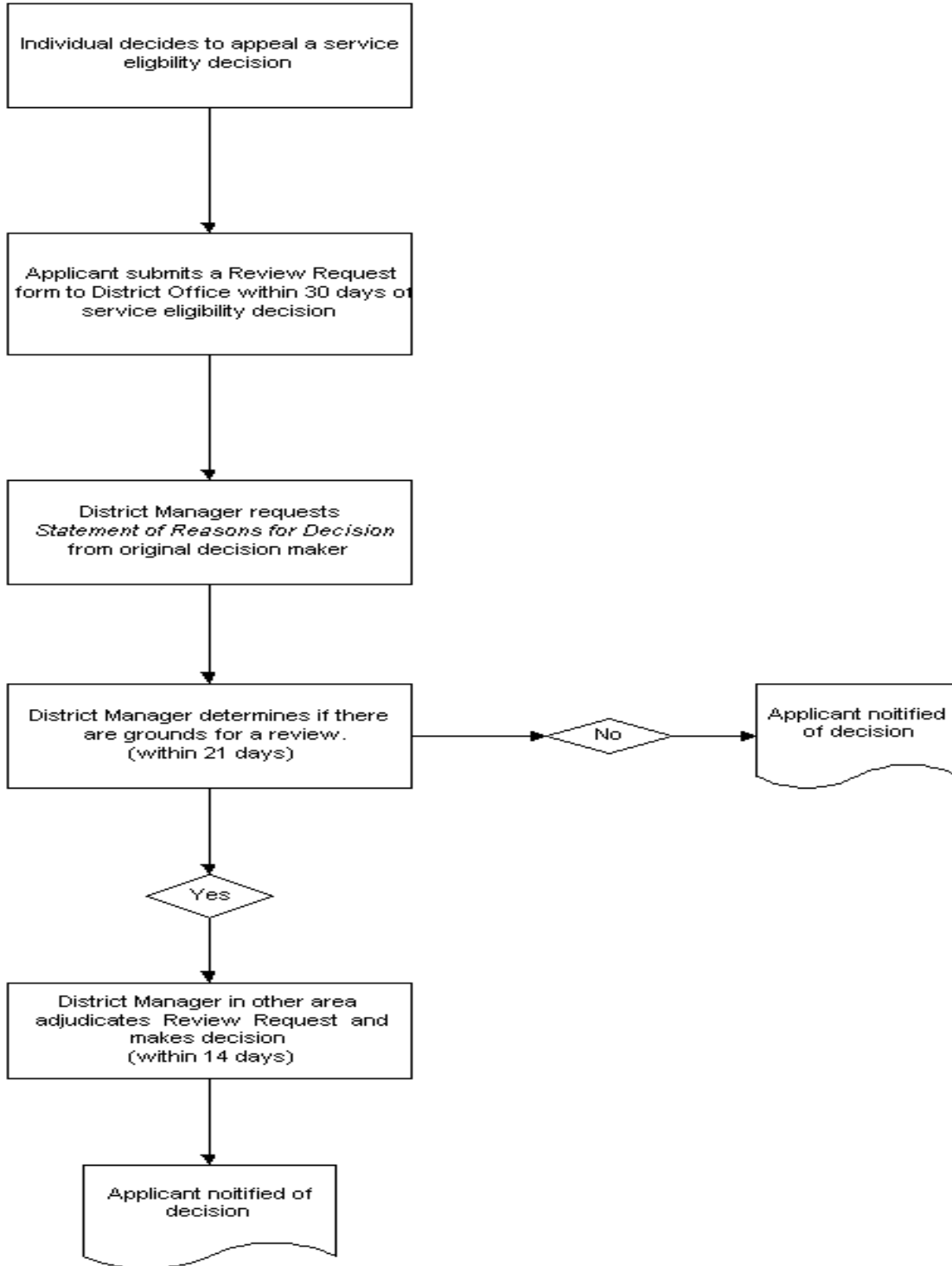
6.0 Service Provision While an Administrative Review is in Process

- 6.1 While an administrative review is in process, the applicant shall receive the authorized level of service as indicated in the decision of the original service decision maker.
- 6.2 While an administrative review is in process, the applicant continues to be subject to all applicable Continuing Care policies.

7.0 Interpretation of Dates

- 7.1 When determining dates as defined in legislation, regulations and policy, they shall be calculated according to the *Interpretation Act*, section 19(k) and section 7(j).
- 7.2 The 30 day period within which an applicant must request an administrative review commences on the day following communication of the original service eligibility decision to the applicant.
- 7.3 The time lines for processes identified in this policy commence on the day following delivery of the *Review Request* to the Continuing Care district office.
- 7.4 For process time lines identified in this policy:
- if the expected completion date falls on a Saturday, the work is to be completed by the end of day on the preceding Friday,
 - if the expected completion date falls on a Sunday, the work is to be completed by the end of day on the following Monday,
 - if the expected completion date falls on a statutory holiday, the work is to be completed by the end of the next regular working day following the statutory holiday.

8.0 Process Flowchart





Review Request
Service Eligibility Decisions – Long Term Care and Home Care

Full name of applicant

Address of applicant

Health card number

Review is being requested by: applicant or other (please provide details)

Name

telephone #

Address

Relationship to applicant

Will the applicant be represented by legal counsel during the review?

yes, (please provide details) no don't know

Name

telephone #

Address

Please give details of decision for which a review is requested.
(If applicable, attach copy of decision or correspondence from Department of Health and Wellness)

Please outline the reasons for your review request.

(Please reference relevant facts, policy and/or law. Attach additional sheets, if required)

Name

Signature

Date

**Nova Scotia Department of Health
Continuing Care Branch**

Subject: Financial Decision Review Policy

Approved On: May 30, 2005. Replaces Policy Dated: January 31, 2005.

Original Signed By

Approved By: _____

Keith Menzies, Executive Director, Continuing Care Branch

1. Application

This policy describes a review and an appeal mechanism for decisions made by the Department of Health regarding *financial assistance*, authorized *accommodation charges*, or *facility per diem rates* for residents or applicants of long term care facilities.

2. Legislation

- 2.1. Decisions related to *financial assistance* are conducted pursuant to the *Social Assistance Act* and regulations as well as the long term care policies of the Department of Health.
- 2.2. Decisions related to the *authorized accommodation charge* and *facility per diem rates* are conducted pursuant to the *Homes for Special Care Act* and regulations as well as the long term care policies of the Department of Health.

3. Definitions

- 3.1. “*Financial assistance*” is assistance received by a “pre-2005 publicly assisted” resident to pay: the “Maximum Accommodation Charge” and/or “Special Needs”. These quoted terms are defined in the Resident Charge and Special Needs policies of the Department of Health’s *Long Term Care Policy Manual*.
- 3.2. “*Authorized accommodation charge*” and the “*facility per diem rate*” are daily charges authorized by the Department of Health as per the Resident Charge Policy, *Long Term Care Policy Manual*.
- 3.3. “*Applicant*” is defined as a resident of a long term care facility or a person seeking admission to a long term care facility.

- 3.4. “*Authorized representative*” is defined to mean:
- any person acting on the *applicant*’s behalf where the *applicant* has given written permission; or
 - a person with enduring power of attorney or power of attorney for the *applicant*; or
 - the individual legal guardian appointed pursuant to the *Incompetent Person’ Act*; and
 - shall not be an employee of the Nova Scotia Department of Health unless that employee is acting on behalf of a member of their family.
- 3.5. “*Original decision-maker*” is defined as the Department of Health employee who made the original financial determination regarding *financial assistance* or an *authorized accommodation charge* or *facility per diem rate* of which the *applicant* or *authorized representative* disagrees.
- 3.6. “*Appeals Tribunal*” is defined as the tribunal established pursuant to the *Employment Support and Income Assistance Act*, and is referenced in the *Social Assistance Act*.

4. Administrative Review

- 4.1. The *applicant* or *authorized representative* may request an administrative review with respect to the following: *financial assistance, authorized accommodation charge, or facility per diem rate*.
- 4.2. The purpose of the administrative review is twofold:
- To ensure that *applicant* or *authorized representative* receive clear explanations of financial determinations; and
 - To provide a timely, administrative process that allows for a second assessment of the original decision.
- 4.3. In all cases where a financial determination has been made a written notice must be provided to the *applicant* or *authorized representative*:
- The decision,
 - The effective date of the decision,
 - The appropriate legislative authority for reaching the decision,
 - All reasons for the decision,
 - The right to an administrative review,
 - The rules, procedures or requirements of the administrative review process, and
 - The right to appeal to the *Appeals Tribunal*. (This right only applies to appeals related to financial assistance as outlined in section 2.1 above.)
- 4.4. The *applicant* or *authorized representative* has thirty (30) days from the day the decision is received, or deemed to be received, to submit a written application for an

- administrative review, if there is disagreement with the decision. (Forty-five (45) days will be accepted if there are extenuating circumstances.)
- 4.5. Written applications for an administrative review may be submitted by fax, mail or in person. See the Appendix for the appropriate form. The application must contain:
- A statement that the *applicant* or *authorized representative* wishes to have a review of the decision,
 - The reason for disagreeing with the decision, and
 - The name, signature, address and telephone number of the person requesting the review.
- 4.6. The administrative review must be completed within 10 calendar days after the receipt of the administrative review request.
- 4.7. The *original decision-maker* must:
- Ensure that the file is prepared for an administrative review with documented decisions and all supporting information used in the decision making process.
 - Be available to answer questions that the reviewer may have regarding the original decision.
 - Not be the reviewer of the decision for the administrative review.
- 4.8. The reviewer must:
- Be authorized to conduct internal reviews and must have the same or higher level of decision-making authority as the *original decision-maker*.
 - Confirm that he/she did not participate in any way in the original decision.
 - Document the administrative review process.
 - Examine the file and the original decision.
 - Determine if the original decision was:
 - o Fair, based on law, merits of the case and all relevant facts,
 - o Consistent with legislation and policies, and
 - o Not the result of administrative error.
 - Make a decision to confirm, vary or reverse the original decision and clearly summarize the reasons for arriving at the decision.
- 4.9. Once a decision is made, a written decision letter that summarizes the results of the review process must be sent to the *applicant* or *authorized representative*. It must explain:
- The reviewer's decision,
 - The information reviewed in making the decision,
 - The rationale for the decision, and if applicable,
 - The right to appeal to the *Appeals Tribunal* and the time limit and procedure for appeal to the *Appeals Tribunal*.
- 4.10. For decisions regarding the *authorized accommodation charge or facility per diem rate*, the reviewer's decision is final and not eligible for an *Appeals Tribunal* hearing.

5. **Appeals Tribunal Hearings**

- 5.1. The purpose of the *Appeals Tribunal* hearing is to provide an *applicant* or *authorized representative* with the opportunity to appeal decisions regarding *financial assistance* and to ensure that the appeal process is consistent with the legislation and policies.
- 5.2. The *applicant* or *authorized representative* cannot proceed to the *Appeals Tribunal* without written confirmation that an administrative review was requested and completed.
- 5.3. To request to continue the *Appeals Tribunal* stage, the *applicant* or *authorized representative* will have ten (10) days to respond to the Coordinator of Appeals in writing (address: Coordinator of Appeals, Department of Community Services, P.O. Box 696, Halifax, Nova Scotia B3J 2T7). Twenty (20) days will be accepted in extenuating circumstances.
- 5.4. If the *applicant* or *authorized representative* does not respond within the given timeframe, the Coordinator of Appeals will notify the Department of Health, and the Department will record that the *applicant* or *authorized representative* accepts the outcome of the administrative review.
- 5.5. If the *applicant* or *authorized representative* does respond within the given timeframe, the Coordinator of Appeals will schedule the appeal and send notification of the date, time and place of the hearing by registered mail to the *applicant* or *authorized representative* ten (10) days prior to the hearing.

6. **Interpretation of Dates**

- 6.1. When calculating dates as defined in legislation, regulations and policy, they shall be calculated according to the *Interpretation Act*, section 19(k) and section 7(j).
- 6.2. The date a decision is communicated or an application for an appeal is received is not counted as the start date for the required timeline. Time line for completion commences on the day following communication.
 - If the due date falls on a Saturday, work must be completed by the preceding Friday
 - If the due date falls on a Sunday, work is due on the following Monday
 - If the due date falls on a holiday, work is due the next day, which is not a holiday.



Appendix
Revised Jan/2005

Review Request
Financial Decisions – Long Term Care

Full name of applicant

Address of applicant

Health card number

Review is being requested by: applicant or other (please provide details)

Name

tel #

Address

Relationship to applicant

Will the applicant be represented by legal counsel during the review?

yes no don't know

If yes, (please provide details)

Name

tel #

Address

Please give details of decision for which a review is requested. (if applicable, attach copy of decision or correspondence from Department of Health)

Continued on Page 2

