# P-2320 Time Limits- Stopping the Clock (continued)

## P-2320B Needed in the Home (24-06)

Participants who feel they cannot take part in activities related to their goals based on caring for a seriously ill or incapacitated family member in the home, may request a code to stop the clock on their countable months due to being needed in the home. Participants will continue to meet with a Reach Up Case Manager while in a needed in the home code to explore future goals and access supports.

The family member must be a parent, spouse, civil union partner or child of the participant requesting the stop the clock. Documentation from the family member's medical provider(s) and/or school is required to help determine if the deferment is needed.

***Needed in the Home documentation***

The Medical Report, Needed in Home form (210NMR) must be signed by the family member (or their authorized rep or parent) needing the care. Their medical provider then completes the rest of the form providing information about the family member's medical condition and their need for care.

Equivalent documentation is acceptable in lieu of the The Medical Report, Needed in Home(210NMR). Equivalent documentation includes obtaining a letter from the family members provider with information about the family members medical condition(s) and how the condition(s) impacts the family member. Verbal confirmation of this information can be accepted and documented in the participant's case note.

The ESD Authorization to Release Information form (201WC) only needs to be completed if the family member is a child and the child is connected with an educational program that would not be included on the 210NMR This will allow contact to be made with the educational program to help determine if the participant is needed in the home due to educational needs as well.

**Active Reach Up participant requests a needed in the home stop the clock code**

Give participant the following form(s) to be completed:

- The Medical Report, Needed in Home(210NMR)

- ESD Authorization to Release Information (201WC) (if appropriate, see explanation of form above)

### *Gathering the medical information*

Create a plan with the participant to provide the medical form(s). If it is helpful to the participant, fax or email paperwork to their provider. Include this plan on the participant's FDP or on their goal sheet.

### *Participant goals during stop the clock request*

Use Stepping Stones and the goal achievement model to see what goal(s) the participant would like to focus on while the deferment request is being determined, and if it is approved. Create a plan with the participant to achieve their goal(s).

For some participants, their goals will focus on the family member for whom they are caring. For other participants, different goals may be discovered through motivational interviewing techniques. Encourage participants to engage in whatever activities they are motivated to take part in.

### *Medical paperwork is not returned*

Meet with the participant to find out if they would like to change their plan, or if there is a good cause reason why they did not return the paperwork. Update the FDP with the new plan or a new deadline for returning the paperwork. Reach out to the provider to assist the participant with the process of obtaining the paperwork.

### *The Medical Report/Needed in Home paperwork is completed and returned*

Update the participation code in ACCESS with the correct review date. Stopping the clock should be based on the providers recommendation and participant's input. The review date should always be the last day of the month, never mid month.  The review date can be entered in ACCESS for a maximum of 6 months but can then be extended if it is determined to still be needed.

### *Sending decision to participant*

Try to review the medical documentation with the participant and discuss the decision. If the participant is not available to meet, send the participant a Deferment Decision form (614DD) with basic information about the decision including dates of when it starts, changes or ends. The form should include an appointment date and time to discuss the decision with the participant.

### ***Participant disagrees with the medical decision***

Consider a redetermination of the medical decision by reviewing current documentation and collecting any additional documentation from the participant's medical provider. If the redetermined decision is still not agreed with, a Fair Hearing can be requested by the participant.

### **Voluntary participation for participants caring for a family member in the home that is seriously ill**

If a participant informs you they are caring for a family member in the home that is seriously ill then the participant can elect for voluntary participation in the Reach Up Program. Discuss with the participant the benefits and supports of working with a Reach Up Case Manager. If the participant is interested in participating in case management services, then schedule a meeting a minimum of monthly by participant preference (phone, virtual, in person, home visit). Work with the participant around identifying a goal using Goal Plan Do Review Revise (GPDR/R) and create a Family Development Plan. All Reach Up Case Management services and supports should be offered, however the participant is not subject to the conciliation or sanction process for non-engagement during this time frame. If the participant is not interested in case management services, then continue to check in a minimum of monthly to ensure participant is aware of services and supports in the event they would like to begin engaging in goal setting. Place the participant in a code 11 in ACCESS and set a review date of three months. Follow the stop the clock procedure as noted above to collect needed in the home documentation. If after three months the participant is requesting more time than you would consult with a Reach Up Supervisor to determine next steps and level of support needed.