SUBCHAPTER 1. GENERAL PROVISIONS

10:16?-1.1 Purpose

The Jersey Assistance for Community Caregiving (JACC) program is a State-funded program that provides older individuals who meet nursing facility level of care, but are not eligible for Medicaid or Medicaid waiver services, with the ability to stay in their homes through the provision of subsidized services that supplement their informal network of caregivers. The program is designed to maximize a participant's autonomy in the management and direction of his or her services. Program participants may employ the providers directly or may delegate the coordination of providers to a care manager.

10:16?-1.2 Scope

The rules in this chapter apply to the target population, the county Area Agencies on Aging, or a designated alternate, and the providers operating under a contract with the Division of Aging Services. All providers and, where applicable, their employees, workers, agents and subcontractors also shall abide by the State laws and regulations pertaining to any licenses, certifications, registrations, permits, accreditations and qualifications required to render any service offered through the JACC program.

10:16?-1.3 Effective date

(a) The rules regarding the income and resources to be considered in determining financial eligibility for the program shall apply to all individuals and applicants who have not yet been enrolled in the program as of the date on which these rules take effect.

(b) For participants enrolled in the program as of the date on which these rules take effect, the rules regarding the income and resources to be considered in determining financial eligibility shall apply at the time when the participant is subject to review and/or re-determination of financial eligibility for the program.

10:16?-1.4 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

“Activity of daily living” or “ADL” means any of the following seven activities used to assess an individual’s eligibility for nursing facility level of care: bathing, bed mobility, eating, dressing, locomotion, toileting and transfers. The ADLs shall be assessed according to the criteria set forth in N.J.A.C. 8:85-2.1(a).

“Adult Day Health services” means services that are furnished on a regularly scheduled basis in an outpatient setting and encompass both the health and social services needed to ensure the optimal functioning of the participant. Such services shall require prior authorization from the Department of Human Services in accordance with N.J.A.C. 10:164-1.5 and shall consist of a minimum of five consecutive hours of structured services per day, but shall not include transportation time, for no more than two days per week. A participant receiving Adult Day Health services shall not be permitted to receive Social Adult Day Care services.

“Applicant” means a person for whom an application or renewal application for services under the program is made.

“Authorized agent” as the term relates to an applicant or participant means a person who is authorized under a power of attorney to act; a legal guardian; a representative payee designated by the Social Security Administration; a staff member of a public or private social services agency of which the applicant or participant is a client and who has been designated by the agency to so act; a close relative by blood or marriage, such as a spouse, parent, child or sibling; a caregiver; or a friend.

“Authorized representative” as the term relates to a participant means any individual, designated by the participant, who is willing and able to assist with or to fulfill the obligations of a participant in the management, direction and verification of the services of a participant-employed provider. An authorized representative shall not be a participant-employed provider.

"Business income" means net income derived from a business, trade, profession or the rental of property after deductions of the ordinary and necessary expenses attributable to that business, trade, profession or rental of property, which are allowed under the federal Internal Revenue Code and regulations issued thereunder.

“Care management agency” means a qualified entity approved by the Division of Aging Services, to administer the JACC program in the specified county. A care management agency shall meet the minimum requirements set forth in N.J.A.C. 10:16?-6.1.

“Care management supervisor” means a qualified individual responsible for the direct supervision of care managers. A care management supervisor shall meet the minimum requirements set forth in N.J.A.C. 10:16?-6.1.

“Care manager” means a qualified individual who, in working with the participant, addresses the needs of the participant as identified in the clinical assessment; develops an appropriate plan of care for the participant; authorizes services for the participant; secures the provider(s) of services for the participant; and effectively manages the services provided to the participant. The care manager assists the participant in understanding the program and the services available. The care manager is responsible for introducing the participant to potential providers, for verifying the qualifications of participant-employed providers, and for assuring that the plan of care is properly implemented. A care manager shall meet the minimum requirements set forth in N.J.A.C. 10:16?-6.1.

“Chore services” means the intermittent and non-routine household maintenance needed to maintain the residence in a clean, sanitary and safe condition and increase the safety of the individual. Chore services shall include, but shall not be limited to, heavy household chores such as cleaning appliances, cleaning and securing rugs and carpets, washing walls and windows, scrubbing floors, and cleaning attics and basements to remove fire and health hazards; moving furniture to provide safe access and egress; clearing walkways of ice, snow and leaves; trimming overhanging tree branches; replacing fuses, light bulbs, electric plugs and frayed cords; replacing door locks and window catches; fixing broken tiles; replacing faucet washers; installing safety equipment; changing of screens and storm windows; installing weather stripping around doors; and caulking windows. A participant shall not receive Chore services when the participant or anyone else in the household is capable of performing the chore; or when anyone else in the household is financially capable of paying for the Chore service; or when a relative, caregiver, landlord, community agency, volunteer or third-party payer is capable of or responsible for completing the chore. Chore services shall not include normal everyday housekeeping tasks such as dusting, vacuuming, changing bed linens, washing dishes or cleaning the bathroom. Utility providers who offer free services shall be utilized first for home weatherization or energy efficiency products. In the case of a rental property, the responsibility of the landlord pursuant to the lease agreement shall be examined prior to the authorization of Chore services. In the case of a community governed by a homeowners association or community trust, the obligations of the association or the trust to make repairs shall be examined prior the authorization of Chore services.

"Clinical eligibility" means a determination made by professional staff, who shall be designated by the Division, and approved by OCCO, based on a standardized assessment that demonstrates that an applicant or participant meets nursing facility level of care in accordance with N.J.A.C. 8:85-2.1. Clinical eligibility shall be valid for one year, after which it shall expire and a re-determination of the individual's clinical eligibility shall be required for participation in the program.

"Co-payment" means the monthly payment required to be made by a participant as his or her contribution towards the cost of the program.

"Department" means the New Jersey Department of Human Services.

"Division" means the Division of Aging Services in the Department.

"Environmental Accessibility Adaptations services" means physical adaptations to a private residence, occupied by the participant as his or her place of principal residence, that are required by the participant's plan of care and are necessary to ensure the health, welfare and safety of the participant or to enable the participant to function with greater independence in the home and without which the participant would require institutionalization. Such adaptations may include the installation of ramps and grab bars; the widening of doorways; the modification of bathroom facilities; or the installation of specialized electrical or plumbing systems to accommodate medical equipment and supplies. This service shall not include any adaptation or improvement that is of general utility and does not provide direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning or adaptations or modifications to motor vehicles.

"Facility licensed by the State" means, but is not limited to, any assisted living facility, long-term care facility, continuing care retirement community, comprehensive personal care home, Class C boarding home or residential health care licensed by the New Jersey Department of Health.

"Fiscal Intermediary" means an entity under contract with the Department or State of New Jersey to provide fiscal and business services for the program, including the payment of program funds to providers for services rendered, the billing and collection of participant co-payments and the preparation of reports for the Division. If a participant hires a participant-employed provider, the Fiscal Intermediary shall function as the participant's agent in performing payroll and other employer responsibilities that are required by federal and State law.

"Home-Delivered Meals services" means the delivery of nutritionally adequate meals to participants who are homebound; incapacitated due to accident, illness or frailty; unable to prepare their meals; and lacking support from other persons, paid or unpaid, to help secure meals. This service shall be limited to one meal per day and shall not include the participant's purchase of commercial frozen food or nutritional supplements directly from service providers.

"Individual Service Agreement" or "ISA" means the form approved by the Division that authorizes JACC providers to provide a service to a participant and to seek payment from the Fiscal Intermediary for rendering the service to the participant. The form shall identify the specific JACC provider; the specific authorized service to be rendered to the participant; the amount and frequency of such service; and the rate of payment for such service.

"Instrumental activity of daily living" or "IADL" means routine activities around the home or in the community such as preparing meals; performing ordinary house work; managing finances; managing medication; using the phone; ascending or descending stairs; using transportation; and shopping.

"JACC Administrative Agency" means the entity at the county level responsible for the administration of the program.

"JACC provider" means a service provider or a participant-employed provider approved and authorized by the Division to render to a participant services identified in the participant's plan of care.

"Lower-mode transportation" means the non-medical transportation of a participant who does not require a wheelchair or a stretcher, such as a taxi, public transportation or van.

"Nursing facility level of care" means the threshold met by an applicant or participant when the standardized assessment demonstrates that the individual satisfies one of the following criteria:

1. The individual requires limited assistance or greater with three of more ADLs;
2. The individual exhibits problems with short-term memory and is minimally impaired or greater with decision-making ability and requires supervision or greater with three or more ADLs; or
3. The individual is minimally impaired or greater with decision-making and, in making himself or herself understood, is usually understood or greater and requires supervision or greater with three or more ADLs.

“Office of Community Choice Options” or “OCCO” means the Office of Community Choice Options in the Division, which is responsible for determining nursing facility level of care and approving determinations of clinical eligibility for the JACC program.

“Participant” means an individual who is receiving services under the program.

“Participant-employed provider” or “PEP” means an individual approved by the Division as a provider of specified services and hired directly by the participant, but shall not include a legal guardian or authorized representative, or any person under the age of 18. A participant-employed provider shall be authorized to provide services only when the participant utilizes his or her option of self-direction. A participant-employed provider shall be authorized to provide only Chore services, Personal Care Assistant services and Transportation services. A participant-employed provider shall be an employee of the participant and shall not be an employee or agent of the Department.

“Personal Care Assistant services” or “PCA” means services identified in the plan of care that assist participants with their activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and/or with health tasks in the home of the participants. ADLs and health tasks shall be performed by a qualified and approved participant-employed provider or, under the supervision of a registered nurse, by a homemaker-home health aide or a personal care assistant who meets the requirements of N.J.A.C. 10:60. This service may include hands on personal care by a qualified individual. This service also may include assistance with meal preparation, grocery shopping, money management, light housework and laundry tasks. A participant shall not receive PCA services while he or she is receiving care or treatment in an acute facility, a subacute facility or a long-term care facility, including but not limited to an assisted living facility, an adult family care home or an assisted living program.

“Personal Emergency Response System services” or “PERS” means an electronic device, either worn or stationary, that enables individuals at high risk of institutionalization to secure assistance in an emergency. A PERS unit also may include an electronic medication-dispensing device that allows for a predetermined quantity of medication(s) to be dispensed in accordance with dosage instructions. A participant shall receive this service only if he or she requires extensive routine supervision and either lives alone or is alone without a regular caregiver for a minimum of six consecutive hours of the day.

“Plan of care” means a written plan for each participant that identifies the participant’s needs and the appropriate services necessary for the participant to remain in the

community. The plan of care includes the participant's personal goals, the participant's choice of JACC providers and the type, frequency and duration of services to be provided. The plan of care shall be signed by both the participant's care manager and the care manager supervisor, which shall not be the same person. The plan of care shall be subject to change in order to meet the needs of the participant.

"Program" means the Jersey Assistance for Community Caregiving program.

"Qualified alien" means a non-citizen who possesses any of the documentation set forth in N.J.A.C. 10:16?-3.5(d).

"Registered nurse" means a person who is licensed by the State of New Jersey as a registered professional nurse pursuant to N.J.A.C. 13:37.

"Resident" means one legally domiciled within the State of New Jersey for a period of 30 days immediately preceding the date of application for the program. Mere seasonal or temporary residence within the State, of whatever duration, shall not constitute domicile.

"Respite Care services" means short-term caregiver services provided to participants unable to care for themselves when there is a need for relief of an unpaid caregiver who has the primary responsibility of providing the participant with daily care and assistance. A participant receiving Respite Care services shall not receive Chore services, Environmental Accessibility Adaptations services, PCA services and Home-delivered meals services. Without prior written authorization from the Division, a participant shall not receive more than a total of 30 days of in-home and/or facility-based Respite Care services per fiscal year, from July 1st through the following June 30th.

"Service provider" means any individual, who is not a participant-employed provider, or any entity that is approved by the Division to provide JACC services and executes a written agreement to provide such services to participants.

"Social Adult Day Care services" means a community-based group program designed to meet the non-medical needs of adults with functional impairments through an individualized plan of care. Social Adult Day Care services shall consist of a structured comprehensive program that provides a variety of health, social and related support services to a participant outside his or her residence in a protective setting during any part of a day, but for less than 24 hours. Such services shall consist of a minimum of five consecutive hours of structured services per day, but shall not include transportation time, for no more than three days per week on a planned basis during

specified hours in accordance with a weekly schedule or routine. A participant receiving Social Adult Day Care services shall not be permitted to receive Adult Day Health services.

“Specialized Medical Equipment and Supplies services” means special products, devices, controls or appliances identified in the plan of care that provide a direct medical or remedial benefit to the participant and enable the participant to increase his or her ability to perform activities of daily living, or enable the participant to perceive, control or communicate with his or her environment. This service shall not include any specialized medical equipment or supplies covered by other programs, plans or insurance.

“Specialized Medical Equipment and Supplies Evaluation services” means the evaluation of an Environmental Accessibility Adaptation service or Specialized Medical Equipment and Supplies service that verifies the viability and adequacy of such service in meeting the participant’s needs and/or that determines the specifications for such service as appropriate and necessary to maintain the health, safety, welfare and functioning of the participant in the community. This service shall be utilized only in conjunction with an assessed need for an Environmental Accessibility Adaptation service or Specialized Medical Equipment and Supplies service as stated in the participant’s plan of care.

"Special needs trust" means a trust, which meets the requirements of N.J.A.C. 10:16?-1.5, containing the assets of a disabled individual that is established for the sole benefit of the individual by a parent, grandparent, legal guardian or court prior to the time the individual reaches the age of 65.

“Standardized assessment” means an in-person assessment of an individual and a review of all available records, using the assessment tool prescribed by the Department, to determine nursing facility level of care according to the criteria set forth in N.J.A.C. 8:85-2.1.

”State” shall mean the State of New Jersey.

“Title III provider” means a provider contracting with the county Area Agency on Aging to provide services funded by Title III of the Older Americans Act, 42 U.S.C. § 3001 et seq., as amended and supplemented.

“Transportation services” means transportation that is required in order to implement the participant’s plan of care or that enables the participant to gain access to JACC services, community services, activities and resources identified in the plan of care. This service shall not include transportation that is incidental to providing another JACC

service. A participant shall not receive Transportation services whenever the participant is capable of availing himself or herself of complementary transportation provided by family, neighbors, friends and community agencies.

“Unpaid caregiver” means a spouse, parent, child, relative or other person at least 18 years of age who has the primary responsibility of providing daily care for the participant and who does not receive financial remuneration for the care.

"Viatical settlement" means the sale or cashing in of a life insurance policy, prior to the death of the insured, due to the fact that the insured has experienced a catastrophic, life-threatening or chronic illness or condition.

10:16?-1.5 Special needs trust

(a) To be considered a special needs trust for the purposes of this chapter, the trust shall include the following provisions:

1. The trust shall state specifically that the trust is for the sole benefit of the trust beneficiary;

2. The trust shall state specifically that its purpose is to permit the use of trust assets to supplement, and not to supplant, impair or diminish, any benefits or assistance of any federal, State or other governmental entity for which the trust beneficiary may otherwise be eligible or which the trust beneficiary may be receiving;

3. The trust shall state specifically the age of the trust beneficiary, that the trust beneficiary is disabled within the definition of 42 U.S.C. § 1382c(a)(3), and whether the trust beneficiary is competent at the time the trust is established;

4. The trust shall identify specifically, in an attached schedule, the source of the initial trust property and all assets of the trust;

5. If the trust makes provisions that are intended to limit invasion by creditors or to insulate the trust from liens or encumbrances, the trust shall state that such provisions are not intended to limit the State's right to reimbursement or to recoup incorrectly paid benefits;

6. The trust shall state that it is established by a parent, grandparent, or legal guardian of the trust beneficiary or by a court;

7. The trust shall state specifically that it is irrevocable. Neither the grantor, nor the trustee, nor the trust beneficiary shall have any right or power, whether alone or in conjunction with others, in whatever capacity, to alter, amend, revoke, or terminate the trust or any of its terms or to designate the persons who shall possess or enjoy the trust estate during his or her lifetime;

8. The trustee shall be identified specifically by name and address. The trust shall state that the original trust beneficiary cannot be the trustee. The trust shall make provisions for naming a successor trustee in the event that any trustee is unable or unwilling to serve;

9. The trust shall state specifically that the trustee shall fully comply with all State laws, including the Prudent Investor Act, N.J.S.A. 3B:20-11.1 et seq. The trust shall state that the trustee cannot take any actions not authorized by, or without regard to, State laws. If the trust gives the trustee authorization or power not provided for in the Prudent Investor Act, the applicant shall submit with his or her application an accompanying letter explaining each such authorization or power;

10. The trust shall state specifically that the trustee shall be compensated only as provided by law and in accordance with N.J.S.A. 3B:18-2 et seq. If the trust identifies a guardian, the trust shall specifically identify the guardian by name. A guardian shall be compensated only as provided by law;

11. The trust shall specify that a formal or informal accounting of all expenditures made by the trust shall be submitted to the appropriate eligibility determination agency on an annual basis; and

12. The money creating the trust, any additions and/or interest accumulated cannot be disposed by will to other parties, but shall pass by intestacy. The trust shall not create other trusts within it.

(b) To maintain status as a special needs trust for the purposes of this chapter, the trustee, applicant or authorized agent shall:

1. Provide prior written notice to the Division and to the trust beneficiary and/or guardian of a change in trustee;

2. Upon request from the Division, submit an annual formal or informal accounting, as specified in the trust, of all expenditures made by the trust; and

3. Provide the Division with written notice 45 days prior to any expenditure in excess of $5,000 and of any amount that would substantially deplete the principal of the trust.

(c) The applicant shall bear the burden of proving that a trust qualifies as a special needs trust for the purposes of this chapter.

SUBCHAPTER 2. ADMINISTRATIVE ORGANIZATION

10:16?-2.1 Department of Human Services

The Department of Human Services is the administrative unit of the State government that has control over the administration of the Jersey Assistance for Community Caregiving program.

10:16?-2.2 Division of Aging Services

The Division of Aging Services is the administrative unit within the Department that processes applications, determines eligibility, authorizes enrollment in the program, establishes co-payment fee schedules, sets rates of compensation for JACC providers and performs other administrative functions for, or in conjunction with, the Department.

10:16?-2.3 JACC Administrative Agency

Each county has a JACC Administrative Agency to serve as the primary entity responsible for developing systems of community-based services for older persons. The JACC Administrative Agency shall administer the Jersey Assistance for Community Caregiving program in the county. The JACC Administrative Agency shall be responsible for coordinating the care for program participants, completing the applications, forwarding completed applications and supporting documentation to the Division for approval, maintaining the participant records and overseeing care managers and the implementation of each participant's plan of care. The JACC Administrative Agency also shall be the entity to whom funding is paid for the administration of the program.

SUBCHAPTER 3. PARTICIPANT ELIGIBILITY AND APPLICATION PROCESS

10:16?-3.1 Eligibility standards

(a) To be eligible to participate in the program, an individual or his or her authorized agent shall apply to the JACC Administration Agency in the county in which the individual resides and the individual:

1. Shall be a resident of the State of New Jersey;

2. Shall be a United States citizen or a qualified alien;

3. Shall be 60 years of age or older;

4. Shall reside in a home that is not a facility licensed by the State;

5. Shall meet the clinical eligibility requirements set forth in this chapter;

6. Shall meet the financial eligibility requirements set forth in this chapter;

7. Shall be financially ineligible for services provided through New Jersey Family Care or its successor program;

8. Shall have no alternate means to secure the services and/or supports needed to remain in the community; and

9. Shall not be receiving services from any other State funded home-based supportive care program.

(b) Notwithstanding paragraph (a)7 above, an individual who is financially eligible for services through New Jersey Family Care or its successor program, but is not yet receiving such services, may be eligible for the program, at the Division's sole discretion, until the date on which the individual is officially determined to be eligible for New Jersey Family Care or its successor program.

(c) Notwithstanding paragraph (a)9 above, the Division, in its sole discretion, may permit an individual who is receiving services from another State funded home-based supportive care program to apply for and enroll in the program on a short-term basis to alleviate a temporary crisis or emergency.

(d) The applicant shall bear the burden of proving eligibility for the program.

(e) The applicant shall submit proof of eligibility, as required in this chapter, with his or her application for the program.

(f) The participant's date of eligibility for the program shall be the latest date on which he or she has been determined by the Division to meet all eligibility requirements for the program.

10:16?-3.2 Residency

(a) The Division shall interpret "residency" as having a customary place of abode in New Jersey.

(b) The Division shall consider absence from New Jersey for a period of 30 days to be prima facie evidence of abandonment of residence.

(c) The Division shall determine whether an applicant or participant has discontinued or abandoned residency in New Jersey based upon contact with the applicant or participant and whether he or she intends to return to New Jersey or to remain indefinitely in another jurisdiction.

(d) An applicant or participant who leaves New Jersey with the intent to establish residency elsewhere shall be ineligible for the program.

10:16?-3.3 Financial eligibility

(a) An individual shall be financially eligible for the program if he or she has income that does not exceed 365% of the Federal Poverty Level and has resources that do not exceed $40,000 for a single person or $60,000 for a married person.

1. If the individual is single, income eligibility shall be determined based on the Federal Poverty Level for one household member.

2. If the individual is married, income eligibility shall be determined based on the Federal Poverty Level for two household members.

(b) If married, the income and resources of a spouse shall be included as the income and resources of the individual.

(c) The Division shall determine income by calculating an individual's average monthly income. The individual shall meet the income threshold if his or her monthly income does not exceed 365% of one-twelfth of the Federal Poverty Level.

(d) Unless there is a law to the contrary, the Division shall consider as income all gross income, except where otherwise specified as net income, from whatever source derived. The Division shall consider all income unless specifically excluded in subsection (e) below. Income shall include, but not be limited to, the following:

1. Social Security benefits paid to or on behalf of the applicant;

2. Veterans benefits, except for aid and attendance benefits;

3. Disability benefits, whether public or private;

4. Salaries;

5. Wages;

6. Bonuses;

7. Commissions;

8. Fees;

9. Dividends;

10. Interest, both taxable and nontaxable;

11. Capital gains;

12. Royalties;

13. Bequests and death benefits;

14. Support payments of any kind, except for child support;

15. Unemployment benefits;

16. Pensions and black lung benefits;

17. Annuities, whether contributory, non-contributory, qualified and non-qualified;

18. Retirement benefits, including distribution from individual retirement arrangements (IRAs), whether traditional, simple, Roth or educational, and benefit payments from foreign countries;

19. Business income;

20. Fair market value of prizes and awards;

21. Gambling and lottery winnings; and

22. Net rental income after deducting expenses as permitted with business income.

(e) The following sources of income shall be excluded:

1. Veterans' aid and attendance benefits;

2. Benefit amounts received under the New Jersey State Lifeline Credit Program/Tenants Lifeline Assistance Program, the Universal Service Fund, the Low-

Income Home Energy Assistance Program and the New Jersey Supplemental Nutrition Assistance Program;

3. Benefits received under New Jersey State Homestead Rebates;

4. Stipends from the Volunteers in Service to America (VISTA), Foster Grandparents programs, Workforce 55+ program and programs under Title V of the Older Americans Act of 1965;

5. Agent Orange payments;

6. Reparation payments to Japanese Americans by the federal government pursuant to sections 105 and 106 of the Civil Liberties Act of 1988, P.L. 100-383 (50 U.S.C. App. 1989b-4 and 1989b-5);

7. Rewards involving health care related fraud or abuse in accordance with N.J.A.C. 10:49-13.4;

8. Holocaust reparations;

9. Proceeds from viatical settlements;

10. Proceeds received by the beneficiary of a special needs trust that meets the requirements of N.J.A.C. 10:16?-1.5;

11. 1035 Tax Free Exchanges of a policy or contract handled between two insurance companies;

12. An insurance policyholder's original contributions if demutualization of the policy occurs, in which case then only the earnings of the policy shall be included as income;

13. Benefits received on behalf of a minor child; and

14. Monies received for disaster relief or disaster assistance, whether private or public funds, or for the settlement of a casualty insurance claim.

(f) The applicant shall be permitted to deduct only the following expenses from his or her income:

1. Expenses permitted for business income and rental income in paragraphs (d)19 and 22 above; and

2. The applicant's Medicare Part B premiums.

(g) The applicant shall not use net losses in one income category to offset income in another category.

(h) The Division shall consider as resources all tangible and intangible assets, whether owned in whole or in part by the applicant, unless the resource is specifically excluded in subsection (i) below. Resources shall include, but not be limited to, the following:

1. Cash or cash equivalents, such as bank accounts, Treasury bills, money market accounts, certificates of deposit and retirement accounts, regardless of whether the applicant is taking distributions;

2. Financial investments, such as annuities, mutual funds, bonds and stocks;

3. Real estate, mobile homes and trailers, regardless of the amount of mortgage or other lien against the property;

4. Vehicles, such as cars, recreational vehicles and motorcycles;

5. Cash surrender value of life insurance policy; and

6. Patents and copyrights.

(i) The following resources shall be excluded:

1. The applicant's primary residence;

2. A time share owned by the applicant;

3. One automobile regardless of value if used for the transportation of the applicant or a member of the applicant's household;

4. The applicant's burial space; and

5. The applicant's personal effects and household goods.

(j) When the applicant is not the sole title owner of a resource, the Division shall determine value based upon the order in which the owners are listed on the resource. The Division shall deem the applicant as the owner of a resource if he or she is the first named owner unless the applicant can provide documentation from the other owner(s) regarding the extent of the applicant's ownership.

10:16?-3.4 Clinical eligibility

(a) An individual shall be clinically eligible for the program if he or she meets nursing facility level of care, in accordance with N.J.A.C. 8:85-2.1, based upon a standardized assessment.

(b) OCCO shall be solely responsible for making the final determination that an individual is clinically eligible for the program.

(c) Whenever the JACC Administrative Agency or care manager has reason to believe that a participant does not continue to meet clinical eligibility, the JACC Administrative Agency shall immediately notify the Division to request a clinical reassessment of the participant.

(d) OCCO shall have the right to assess the clinical eligibility of an applicant or participant at any time.

10:16?-3.5 Proofs of eligibility

(a) Individuals enrolled in the Pharmaceutical Assistance to the Aged and Disabled Program or the Senior Gold Prescription Program shall not be required to submit proof of residency, age or citizenship unless such proof is requested by the Division.

(b) Except as provided in subsection (a) above, the applicant shall provide the JACC Administrative Agency with a copy of one of the following valid proofs of current residency:

1. Driver's license or government issued identification;

2. SSA benefit verification letter;

3. Landlord's rent records and receipts;

4. Public utility records and receipts, such as telephone bill or electric bill;

5. Property tax assessment records;

6. Bills from businesses or professionals, such as doctors or department stores;

7. Post Office records;

8. Records of social agencies, public or private; or

9. Employment records.

(c) The applicant shall provide the JACC Administrative Agency with valid proof of current gross income and current value of resources. Such proof shall not include any financial statement printed from any website, but shall include the following:

1. A complete copy of the most recently filed and signed federal and State tax returns, with schedules;

2. Copies of paper statements prepared and issued by financial institutions or investment entities containing the complete account number(s) for each account and current amount or value of each resource;

3. Documentation and/or information necessary for the Division to identify and verify the current value of each resource; and

4. If the complete account number or valuation of a resource is not provided on a paper statement, then the applicant must submit an original letter prepared by the financial institution or investment entity on its official stationery wherein the financial institution or investment entity verifies the complete account number and current valuation of the resource.

(d) If applicable, the applicant shall provide the JACC Administrative Agency with a copy of one of the following proofs of current qualified alien status, which shall include an expiration date:

1. INS Form I-551;

2. A temporary I-551 stamp in a foreign passport;

3. INS Form I-94 annotated with stamp showing entry as refugee;

4. INS Form I-688B;

5. INS Form I-766; or

6. INS Form I-571.

(e) If requested by the Division, the applicant shall provide the JACC Administrative Agency with adequate proof of age and/or citizenship.

10:16?-3.6 Completing the application forms

(a) The applicant shall provide the Division or its authorized agents with current, accurate and complete information.

(b) The applicant shall provide the Division or its authorized agents with all required and necessary documentation as valid proof of eligibility for the program. If the applicant fails to respond within 45 days to a request for any of the required and necessary documentation, the JACC Administrative Agency shall deny the application and the applicant shall be required to submit a new application.

(c) If an authorized agent is acting under a power of attorney, the applicant shall include the document granting such authority with the application.

(d) The applicant or authorized agent shall read the certification on the application form and sign or mark the application form, certifying that the information on the form is true and accurate to the best of the signer's knowledge.

1. If applicable, the person preparing the application form on behalf of an applicant shall sign or mark the application form as the preparer.

2. If the applicant is married, the spouse shall sign or mark the application form.

(e) By signing or marking the application form, the applicant or authorized agent and applicant's spouse, if applicable, authorize the following:

1. The Division or its authorized agents to verify any information on the application form by contacting the Social Security Administration, the Internal Revenue Service, the New Jersey Division of Taxation, employers, pension payers and other entities as needed to verify eligibility; and

2. The Division or its authorized agents to visit the applicant.

(f) By signing or marking the application form, the applicant or authorized agent and applicant's spouse, if applicable, consent to the following:

1. Assisting the Division or its authorized agents in accessing or obtaining information and documentation in order to verify information on the application form and in accessing or obtaining any records related to program participation;

2. Submitting to random quality control review by the Division or its authorized agents, the refusal of which may result in disenrollment from the program; and

3. Re-applying for the program upon request by the Division.

(g) The applicant shall complete a renewal application whenever he or she has received an increase in income and/or resources, has been enrolled in the program for one year or at the request of the Division. This requirement, however, shall not apply to the usual and customary cost of living adjustments to income from government funded sources.

10:16?-3.7 Responsibilities of the JACC Administrative Agency in the application process

(a) Utilizing the screening process promulgated by the Division, the JACC Administrative Agency shall screen an applicant in order to assess eligibility for the program.

(b) If the JACC Administrative Agency determines that the applicant satisfies the eligibility requirements, the JACC Administrative Agency shall submit a completed application, valid proofs of eligibility and any other supporting documentation to the Division for a determination of program eligibility. Except as provided in N.J.A.C. 10:16?-3.5(a), the JACC Administrative Agency shall include the following documentation with the application:

1. Proof of residency;

2. Proof of current income and current value of resources;

3. Documentation of the applicant’s screen for community service;

4. Proof of status as qualified alien, if applicable;

5. The applicant's authorization and/or consent regarding the application process; and

6. Any other documentation as may be required for the Division to process the application and determine program eligibility.

(c) The JACC Administrative Agency shall explain the program and provide program information to each applicant who completes an application. The JACC Administrative Agency shall provide such information in the applicant's preferred language and, if necessary, shall utilize the professional translation of Language Line or a successor translation service approved by the Division.

(d) The JACC Administrative Agency shall maintain files for each applicant and participant, including applications, proofs of eligibility and any other supporting documentation.

(e) The JACC Administrative Agency shall retain records for a period of seven years after each applicant or participant ceases activity with the program.

10:16?-3.8 Notification of program eligibility

(a) Upon completing review of the application, the Division shall send written notification to each applicant advising whether he or she is eligible for the program.

(b) The Division shall provide to the JACC Administrative Agency a copy of each applicant's written notification of program eligibility.

(c) Whenever the Division has determined that an applicant or participant is not eligible for the program, the applicant or participant shall have the right to appeal such determination in accordance with N.J.A.C. 10:16?-8.1.

10:16?-3.9 Waiting list

(a) If enrollment in the program is at capacity due to the county's funding, the JACC Administrative Agency shall establish and maintain a single waiting list for those applicants whose eligibility for the program has been screened by the JACC Administrative Agency, but whose enrollment into the program cannot be completed due to the funding limitations. The JACC Administrative Agency shall maintain the list in chronological order based upon the date on which the applicant sought program services.

(b) When a waiting list is required, the JACC Administrative Agency shall complete the application screening process for applicants in order to maintain a predetermined number of pre-approved applicants on the list. Once the predetermined number of pre-approvals has been met, the JACC Administrative Agency shall maintain the waiting list using only the contact information for the remaining applicants on the waiting list.

1. The JACC Administrative Agency shall determine the number of pre-approved applicants to be maintained on the waiting list by calculating 10 percent of the number of participants that could be supported by the county's current funding for the program.

2. The number shall be rounded down to the nearest whole number.

3. The JACC Administrative Agency shall recalculate the number whenever funding for the program is adjusted.

(c) As capacity becomes available, the JACC Administrative Agency shall process the pre-approved applicants from the waiting list in chronological order on a first-come, first-served basis.

(d) Once a waiting list has been created, the JACC Administrative Agency shall monitor the program funding regularly and, if capacity becomes available, shall contact the first applicant on the list. If an applicant on the list desires to participate in the program, the JACC Administrative Agency shall re-evaluate the applicant's eligibility in the program and, if clinical eligibility has expired, request from the Division a re-determination of the applicant's clinical eligibility. If the Division determines that the applicant is eligible, then the Division shall authorize enrollment of the applicant in the program.

(e) The JACC Administrative Agency shall review and adjust the waiting list at least once each calendar year.

(f) Whenever a participant who is enrolled in the program relocates to a county with a waiting list, the participant shall continue his or her enrollment in the program without interruption and shall receive program services from the county in which he or she has relocated. The relocated participant shall not be placed on a waiting list.

10:16?-3.10 Renewal of eligibility

(a) Each participant shall be subject to an annual review of clinical and financial eligibility as required by this chapter.

(b) Unless clinical eligibility has been waived or deemed by the Division as provided in subsections (d) and (e) below, the JACC Administrative Agency shall insure that each participant is reassessed for clinical eligibility every 12 months from the date of the participant's most recent clinical assessment, or whenever there has been a significant change in the participant's status.

1. A care manager shall reassess the clinical eligibility of each participant by completing the assessment process and tool(s) prescribed by the Division.

2. If the outcome of the clinical reassessment indicates that the participant meets clinical eligibility, based on the Division's prescribed assessment process and tool(s), then the participant shall continue to be enrolled in the program as long as he or she does not meet the grounds for disenrollment as set forth in this chapter.

3. If the outcome of the clinical reassessment indicates that the participant may not meet clinical eligibility, based on the Division's prescribed assessment process and tool(s), then the JACC Administrative Agency shall forward the completed assessment to OCCO for a review and final determination of clinical eligibility.

4. If OCCO determines that the participant does not continue to meet clinical eligibility, the Division shall notify the participant and the JACC Administrative Agency and the participant shall be disenrolled from the program in accordance with this chapter.

(c) The JACC Administrative Agency shall insure that a care manager reassesses the financial eligibility of each participant annually, or upon a change in the participant's finances.

1. The care manager shall require the applicant to complete and sign a renewal application after the applicant has been enrolled in the program for one year. Thereafter, the care manager shall meet annually with each participant to reassess financial eligibility and to recalculate the co-payment.

2. If, at any time, the participant received an increase in income in excess of the usual and customary cost of living adjustment to income from government sources

and/or an increase in assets, the care manager shall have the participant complete and sign a renewal application for the program in accordance with N.J.A.C. 10:16?-3.6.

3. The care manager shall submit the completed renewal application, along with the necessary supporting documentation, to the Division for a re-determination of financial eligibility.

4. If the Division determines that the participant does not continue to meet financial eligibility, the Division shall notify the participant and the JACC Administrative Agency and the participant shall be disenrolled from the program in accordance with this chapter.

(d) Upon request, the Division may waive the annual reassessment of clinical eligibility for a participant if OCCO determines there is no reasonable expectation of improvement in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity.

1. For clinical eligibility to be waived, the JACC Administrative Agency shall submit a request for waiver of reassessment to OCCO at least 45 days prior to the participant's date of annual reassessment. The JACC Administrative Agency shall include with the request the relevant medical records documenting participant's chronic condition and/or degree of impairment, written certification from the participant's treating provider stating that there is no reasonable expectation of recovery and any other relevant documentation or information as may be requested by OCCO.

2. At its discretion, OCCO may conduct an additional assessment of the participant if the documentation does not substantiate the participant's condition or impairment.

3. If OCCO determines that waiver of clinical eligibility is warranted, then the Division shall notify the JACC Administrative Agency accordingly and annual reassessment of the participant's clinical eligibility shall not be required for the remainder of the participant's enrollment in the program.

4. If OCCO determines that a waiver of clinical eligibility is not warranted, then the Division shall notify the JACC Administrative Agency of the determination and the participant shall be required to follow the procedures for annual clinical reassessment in accordance with this chapter.

(e) Upon request, the Division may deem clinical eligibility of a participant if there is good reason to believe that the participant does not continue to meet nursing facility level of care solely as a result of receiving JACC services and that, upon a disenrollment from the program, the participant would likely experience a deterioration of his or her condition to the extent that he or she would meet nursing facility level of care within 30 days of disenrollment.

1. For deemed clinical eligibility, the JACC Administrator shall submit a request to OCCO at least 45 days prior to the participant's date of annual reassessment. The JACC Administrator shall include with the request a summary justifying the request, the participant's current plan of care, relevant medical records and assessments supporting continued eligibility and any other relevant documentation or information as may be requested by OCCO.

2. At its discretion, OCCO may conduct an additional assessment of the participant if the documentation does not substantiate the participant's condition.

3. If OCCO determines that clinical eligibility shall be deemed, then the Division shall notify the JACC Administrator accordingly and clinical eligibility shall be deemed clinically eligible until the participant is scheduled for the annual clinical reassessment in accordance with this chapter. For each year thereafter, as may be appropriate, the participant shall be required to submit a request to deem clinical eligibility.

4. If OCCO determines that the participant does not continue to meet nursing facility level of care and his or her request for deeming clinical eligibility is denied, the Division shall notify the participant and the JACC Administrative Agency of the determination and the participant shall be disenrolled from the program in accordance with this chapter.

10:16?-3.11 Confidentiality and disclosure of information

(a) All personally identifiable information regarding applicants and participants obtained or maintained under the program shall be confidential and shall not be released without the consent of the applicant, participant or authorized agent.

(b) Disclosure of information without consent of the applicant or participant, or his or her authorized agent, shall be limited to circumstances directly connected with the administration of the program pursuant to State law and regulations.

(c) The prohibition in this section against unauthorized disclosure shall not be construed to prevent:

1. The release of statistical or summary data or information in which applicants or participants cannot be identified;

2. The release to the Attorney General, or other legal representative of the State, of information or files relating to the claim of any applicant or participant, or his or her authorized agent, challenging the program's statutes, rules or a determination made pursuant thereto, or against whom an action or proceeding for the recovery of incorrectly paid benefits has been instituted;

3. The release of information or files to the State Treasurer, the Commissioner of the Department or other governmental agency, or to their duly authorized representatives, for an audit, review of expenditures or similar activity authorized by law;

4. The release of information or files to any law enforcement authority charged with the investigation or prosecution of violations of the criminal laws of this State; or

5. The release of information where authorized or required by law.

SUBCHAPTER 4. PROGRAM PROCEDURES, REQUIREMENTS AND LIMITATIONS

10:16?-4.1 Program enrollment

(a) The participant's date of enrollment into the program shall be either the date of financial and categorical eligibility or the date of clinical eligibility, whichever is later.

(b) To receive services under the program, the participant shall sign a Participant Enrollment Agreement.

(c) No participant shall receive services until the Participant Enrollment Agreement is signed. Retroactive authorization or enrollment shall be prohibited. The Division shall not pay for any service rendered prior to the date on which the Participant Enrollment Agreement is signed.

10:16?-4.2 Care management

(a) A care manager supervisor, in conjunction with the JACC Administrative Agency, has direct responsibility for the operation of the JACC Care Management services and shall be responsible for, but not limited to, the following:

1. Providing direct supervision of the care managers assigned to participants;

2. Implementing program policies and procedures to ensure delivery of care management services in a manner that provides participants the opportunity to direct their care needs and choose their JACC providers;

3. Monitoring compliance with Division policies and procedures;

4. Overseeing the implementation of the participant's plan of care, quality assurance, program evaluation and consumer advocacy;

5. Providing orientation, training and professional development for care managers;

6. Assigning participants to care managers, signing each participant's plan of care after completed by care managers and monitoring care management to ensure program requirements are met;

7. Providing technical assistance to care managers;

8. Facilitating and coordinating quality assurance and quality improvement activities as requested by the Division; and

9. Preparing reports and conducting audits as requested by the Division.

(b) The JACC Administrative Agency shall assign a care manager to each participant upon his or her enrollment in the program.

(c) Once a participant is assigned, the care manager shall:

1. Contact the participant within three business days of receiving his or her referral;

2. Conduct an in-home visit with the participant within seven business days of receiving his or her referral;

3. Sign and complete the participant's plan of care within 30 days of receiving the referral;

4. Contact the participant a minimum of once each month; and

5. Visit the participant at least once every three months and, within every six months, one of those visits shall take place in the residence of the participant.

(d) In collaboration with the participant, the care manager shall assess the needs of the participant and shall develop the participant's plan of care based upon the clinical assessment. The plan of care shall address and authorize the type, amount, frequency, duration and JACC provider of each service and any unique requirements for the provision of the service.

(e) The care manager shall oversee and monitor the participant, the JACC provider and the delivery of services to ensure compliance with the program and the participant's plan of care.

(f) The care manager shall be responsible for calculating the participant's co-payment, if any, in accordance with this chapter.

(g) The care manager shall be responsible for the preparation and completion of the Individual Service Agreement. The ISA shall be signed by the JACC provider and the care manager.

(h) The care manager shall be responsible for monitoring and advising participants who are at risk of disenrollment from the program.

(i) The care manager shall promptly notify the JACC Administrative Agency whenever a participant notifies the care manager of a change in circumstances as required pursuant to N.J.A.C. 10:16?-4.7(a).

10:16?-4.3 Co-payments

(a) If required pursuant to subsection (f) below, the participant shall pay a co-payment for each month that the participant is enrolled in the program. The participant shall make the payment as directed by the Division. The participant shall pay the co-

payment even if the participant is unavailable to receive services. Except where authorized by the Division in accordance with this chapter, the co-payment amount shall not be waived.

(b) The care manager shall calculate the co-payment by using the participant's monthly income. A participant's monthly income shall be determined in accordance with N.J.A.C. 10:16?-3.3(d) and (e) and, if applicable, shall include the spouse's income.

(c) For the purposes of calculating the co-payment, the participant may elect to deduct from his or her income a standard deduction amount established by the Division or deduct the following itemized monthly deductions:

1. Supplemental medical insurance premiums for the participant;

2. Long-term care insurance premiums for the participant; and

3. Liability and worker's compensation insurance to cover participant-employed provider(s).

(d) When calculating the participant's co-payment, the care manager shall reduce the participant's countable monthly income by either the amount of the standard deduction or the itemized monthly deductions in order to determine the participant's adjusted monthly income.

(e) The co-payment shall be based upon the most current Federal Poverty Level (FPL) guidelines, as amended and published in the Federal Register by the United States Department of Health and Human Services.

(f) The care manager shall determine a participant's co-payment based upon the participant's adjusted monthly income and the FPL for a one-member household if the participant is single or a two-member household if the participant is married. The co-payment amount shall be calculated, by rounding off to the nearest percentage of the FPL, as follows:

For adjusted monthly income that is:	the co-payment shall be:
0 to 133% of FPL	$ 0 per month;
Greater than 133% to 175% of FPL	$15 per month;
Greater than 175% to 225% of FPL	$30 per month;
Greater than 225% to 275% of FPL	$60 per month;

Greater than 275% to 325% of FPL	$90 per month; and
Greater than 325% to 365% of FPL	$120 per month.

(g) At the times directed by the Division, the care manager shall review the co-payment calculations every six months and shall recalculate the participant's co-payment every 12 months. The care manager shall recalculate the co-payment more frequently when necessary to address any change in a participant's income or deductions.

(h) The Division, in its sole discretion, may suspend the requirement for a participant to make the monthly co-payment for not more than two consecutive months if the participant has not received any JACC services during such period for any of the following reasons:

1. The participant has been admitted to an acute facility, subacute facility or long-term facility;

2. There has been an emergency with the participant's unpaid caregiver; or

3. The participant has experienced an unforeseen crisis.

10:16?-4.4 Funding limitations of program benefits

(a) Program benefits shall be limited by the amount of funding allocated to each AAA.

(b) Services requested by a participant shall not be guaranteed. The availability of services shall be dependent upon the allocation of funding and the availability of JACC providers.

(c) Except where authorized by the Division, no participant shall receive benefits in excess of $600 per month or $7,200 per year. This amount of benefits shall not include the cost of care management.

1. The Division, in its sole discretion, may authorize a participant to exceed the monthly limit of $600 or the annual limit of $7,200.

2. The JACC Administrative Agency, on behalf of the participant, shall submit to the Division a request to exceed the cost limitation if the JACC Administrative Agency determines that funding is sufficient to support the request.

3. The JACC Administrative Agency shall not approve any excess expenditure until receiving prior written approval from the Division.

(d) Services shall have cost limitations in accordance with subchapter 7.

(e) The Division shall not pay a participant's legal guardian or authorized representative for services that he or she renders to the participant.

(f) The Division shall not pay a JACC provider for services that are covered or reimbursed under Medicare and/or any other federal or State government program or plan of assistance or under an insurance contract.

10:16?-4.5 Recipient of other assistance and coverage

(a) All usual and customary supports and volunteer resources and services shall be utilized by the participant prior to obtaining JACC services.

(b) If a participant's services are covered in whole or in part by any other federal or State government program or plan of assistance or by insurance contract, the other program or plan or the insurance carrier shall be the primary payer for the services and the JACC program shall be the payer of last resort.

10:16?-4.6 Compliance with terms and conditions

(a) Each participant shall abide by the terms and conditions of the program and the Participant Enrollment Agreement.

(b) Each participant shall receive a minimum of two services, one of which shall be care management services, to maintain enrollment in the program.

(c) A participant's failure to comply with the terms and conditions of the program or the Participant Enrollment Agreement may result in his or her disenrollment from the program as provided in N.J.A.C. 10:16?-4.8.

(d) The Division may take all necessary action to recover the cost of incorrectly paid benefits including, but not limited to:

1. Payment made on behalf of a participant whose services are covered in whole or in part by another source;

2. Payment made on behalf of a participant who was determined incorrectly to be eligible for the program or who became ineligible for the program after a correct determination of eligibility; and

3. Payment made as a result of fraud perpetrated by a participant, his or her authorized agent and/or a JACC provider.

10:16?-4.7 Notification required

(a) A participant shall immediately notify the care manager when any of the following occurs:

1. His or her address changes;

2. His or her marital status changes;

3. His or her income, or a spouse's income, changes;

4. Resources exceed $40,000 if single or $60,000 if married;

5. His or her disability benefits from the Social Security Administration are halted or the nature of the disability changes; or

6. He or she becomes eligible for services provided through New Jersey Family Care or its successor program.

(b) The JACC Administrative Agency shall promptly notify the Division of any changes in subsection (a) above.

10:16?-4.8 Disenrollment from the program

(a) The Division shall disenroll a participant from the program when any of the following occurs:

1. The participant relocates outside the State of New Jersey;

2. The participant moves into a facility licensed by the State;

3. The participant becomes eligible for services provided through New Jersey Family Care or its successor program;

4. The participant does not meet the financial eligibility criteria;

5. The participant does not meet the clinical eligibility criteria;

6. The participant does not require the services offered under the program;

7. The participant willfully exploits, defrauds or abuses the services or program.

(b) In its sole discretion, the Division may disenroll a participant from the program for any of the following reasons:

1. The participant fails to abide by the Participant Enrollment Agreement, the plan of care or the rules of the program, such as maintaining contact with the care manager or submitting to random quality control review;

2. The participant fails to pay the full amount of the co-payment for two consecutive months;

3. The participant is late in paying the co-payments at least three times in a six month period;

4. The participant relocates to an area in which JACC services are not available;

5. The participant fails to provide the Division with requested documentation;

6. The participant refuses services;

7. For two months, the participant has not received services and/or the care manager is unable to contact the participant or locate the participant at his or her last known address;

8. The participant has been admitted to an acute facility, a subacute facility or a long-term care facility for at least 30 consecutive days;

9. The participant leaves the State or vacates his or her residence for at least 30 consecutive days;

10. The amount or cost of services required to adequately care for the participant exceeds the scope and/or limits of the program; or

11. JACC providers are unwilling and/or unable to provide services due to concern for the safety of the participant and/or the JACC providers.

(c) Whenever there are grounds for disenrollment, the care manager shall promptly notify the Division of the specific circumstances and the evidence to support disenrollment from the program.

(d) The Division shall notify the JACC Administrative Agency and the participant, in writing, of disenrollment from the program. The notice shall state the reason(s) for disenrollment and shall advise that the participant may appeal the determination in accordance with N.J.A.C. 10:16?-8.1.

(e) A participant who appeals his or her disenrollment in accordance with N.J.A.C. 10:16?-8.1 shall have the option to continue to receive services until the Department issues a written decision after the administrative hearing or Department issues a final agency decision, whichever is later. If the participant continues to receive services while the appeal is pending shall pay any co-payment amount required in accordance with this chapter.

(f) Disenrollment from the program shall occur no less than 30 days from the date of the notice.

(g) The participant shall be responsible to pay a JACC provider for any service rendered on or after the date on which disenrollment becomes effective.

(h) Any individual who has been disenrolled may reapply for the program. The individual shall be considered a new applicant and his or her application shall be processed as a new application.

(i) The Division, in its sole discretion, shall have the authority to forego disenrollment of a participant, place the participant on inactive status for not more than two consecutive months and suspend the participant's co-payment if the participant has not received any JACC services during such period for any of the following reasons:

1. The participant has been admitted to an acute facility, subacute facility or long-term facility;

2. There has been an emergency with the participant's unpaid caregiver; or

3. The participant has experienced an unforeseen crisis.

10:16?-4.9 Participants exercising the self-directed option

(a) Each participant that exercises the self-directed option of employing a PEP of his or her choice and not a service provider shall fulfill all legal obligations as an employer.

(b) Each participant exercising the self-direction option shall cooperate with the Fiscal Intermediary.

(c) The Fiscal Intermediary shall be responsible to assist and oversee each participant exercising the self-directed option to ensure compliance with all employer-related laws and regulations and program requirements including, but not limited to, payroll, withholdings, insurance, employee records and reporting requirements.

SUBCHAPTER 5. SERVICE REQUIREMENTS, RESTRICTIONS AND LIMITATIONS

10:16?-5.1 General limitations of benefits

(a) Except for facility-based Respite Care services, the Division shall not pay for services rendered in a long-term care facility by a long-term care facility provider.

(b) Other than care management services and PERS, participants shall not receive services during admission to an acute facility, a subacute facility or a long-term care facility.

10:16?-5.2 Adult Day Health services

(a) A participant shall not receive Adult Day Health services for the sole purpose of receiving medication administration or occupational, physical and/or speech therapy.

(b) If the participant's plan of care includes occupational, physical and/or speech therapy in addition to Adult Day Health services, the service provider shall include any

such therapy as part of this service in accordance with N.J.A.C. 8:43F-6.1. The service provider shall include the transportation to off-site occupational, physical and/or speech therapy as part of this service, in accordance with N.J.A.C. 8:43F-17.1, if the participant is scheduled to receive such therapy on a day on which he or she is receiving Adult Day Health services.

(c) The service provider shall provide the participant with transportation between his or her residence and the service provider's facility as a part of this service. The cost of transportation shall be included in the rate of compensation to the service provider for this service. The service provider shall not bill the cost of transportation as a separate service.

10:16?-5.3 Chore services

(a) If the participant resides in a rental property, the care manager shall determine the landlord's responsibility under the lease agreement prior to authorizing this service.

10:16?-5.4 Environmental Accessibility Adaptations services

(a) Environmental Accessibility Adaptations services shall be provided in accordance with applicable federal, State and local building codes, the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12101 et seq., as amended, and the most current ADA Accessibility Guidelines (ADAAG) and Specifications.

(b) Upon reasonable request, the service provider shall make available to the Division evidence of permits and approvals issued by municipal authorities or agencies.

(c) The care manager shall obtain prior authorization from the Division for any service expenditure of $500 or more.

(d) Services shall not include the addition of total square footage to the residence of a participant unless necessary to complete the service, such as the improvement to an entrance/egress or the configuration of a bathroom to accommodate a participant's wheel chair.

(e) If the participant resides in a rental property, the service provider shall obtain the landlord's prior written consent and assurances from the participant and the landlord that the participant will occupy the premises for at least one year after completion of the service.

(f) Any participant who sells his or her residence within six months of completion of an adaptation shall be liable to reimburse the Division for the expense of the service from the proceeds of the sale of the property.

10:16?-5.5 Home-Delivered Meals services

(a) Home-Delivered Meals services shall provide the participant with a minimum of one-third of the current Dietary Reference Intakes (DRI) established by the Food & Nutrition Board of the National Academy of Sciences and National Research Council.

(b) One meal shall equal one unit of service for the purpose of determining the rate of compensation to the service provider. The service provider's rate of compensation shall be based on the average cost per meal, which shall include food, labor, preparation and delivery costs, and the service provider shall not bill such costs as separate services.

(c) The participant may obtain Home-Delivered Meals services from more than one service provider.

(d) When a participant's needs cannot be met due to unavailability of services, special dietary needs or constraints or the provider's waiting list, the participant may obtain meals from any other approved service provider in the participant's area.

10:16?-5.6 Personal Care Assistant services

(a) A service provider shall be qualified to perform PCA services involving ADLs or health related tasks and shall perform such services only under the direction of a registered nurse.

(b) PCA services may include assistance with the preparation of meals, but shall not include the cost of the ingredients for the meals.

(c) The JACC provider shall not bill the cost of transportation as a separate service.

10:16?-5.7 Personal Emergency Response System services

(a) Each PERS shall be connected to a response center.

(b) The service provider shall staff the response center with personnel trained in emergency response.

10:16?-5.8 Respite Care services

(a) The cost of room and board shall be included in the rate of compensation to the service provider for facility Respite Care services. The service provider shall not bill the cost of room and board as a separate service.

10:16?-5.9 Social Adult Day Care services

(a) The service provider shall provide the participant with a minimum of one nutritionally balanced meal per day and nutritionally appropriate snacks. This requirement also shall apply to participants with special dietary needs.

10:16?-5.10 Specialized Medical Equipment and Supplies services

(a) The care manager shall obtain prior authorization from the Division for any service expenditure of $250 or more in any one month.

(b) All items provided to the participant as part of this service shall meet applicable standards of design, manufacture and installation and shall be provided in accordance with applicable federal, State and municipal codes. Upon reasonable request, the service provider shall make available to the Division evidence of permits and approvals issued by municipal authorities or agencies.

10:16?-5.11 Specialized Medical Equipment and Supplies Evaluations

(a) The service provider shall verify the viability and adequacy of requested or intended equipment in meeting the participant's needs or to determine specifications for appropriate equipment.

(b) The service provider shall not be permitted to verify the viability and adequacy of its own equipment.

10:16?-5.12 Transportation services

(a) The Division shall not pay JACC providers for transportation incidental to the provision of another service.

(b) All Transportation services shall be lower-mode transportation. Transportation services also shall include the use of public transit and fare when it is available, cost-effective and appropriate to the participant's needs and capabilities.

SUBCHAPTER 6. PROVIDER REQUIREMENTS

10:16?-6.1 Requirements for care management.

(a) A care management agency shall meet the following minimum requirements:

1. Be an Area Agency on Aging, a County Welfare Agency, a licensed certified Home Health Agency, an accredited registered Homemaker Agency, a proprietary or not-for-profit care management agency or a Center for Independent Living;

2. Execute a written agreement with the Division in order to provide care management services for the program; and

3. Employ at least one care management supervisor who meets the requirements set forth in subsection (b) below.

(b) A care management supervisor shall meet the following minimum requirements:

1. Be a licensed or certified social worker in accordance with N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G; a registered nurse in accordance with N.J.S.A. 45:11-23 et seq. and N.J.A.C. 13:37; or a graduate of an accredited college or university with a Bachelor's degree, or higher, in a health-related field or behavioral science field; and

2. Have 1,600 hours of compensated work or internship experience with the elderly or physically disabled in an institutional or community setting, which shall have been performed in a full-time position of at least 35 hours per work week; and

3. Be employed by a care management agency.

(c) A care manager shall meet the following minimum requirements:

1. Be a licensed or certified social worker in accordance with N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G; a registered nurse in accordance with N.J.S.A. 45:11-23 et seq. and N.J.A.C. 13:37; or a graduate of an accredited college or university with a Bachelor's degree, or higher, in a health-related field or behavioral science field; and

2. Have 1,600 hours of compensated work or internship experience with the elderly or physically disabled in an institutional or community setting, which shall have been performed in a full-time position of at least 35 hours per work week; and

3. Be employed by a care management agency; and

4. Within the first 30 days of employment as a care manager, complete an orientation provided by the care management agency regarding the Aging and Disability Resource Connection process; and

5. Attend annually a minimum of one continuing education training course or seminar on aging and/or disability related subjects.

(d) The license, certification and educational requirements for care manager supervisors and care managers may be waived for any care manager supervisor or care manager employed in such position prior to December 31, 2016.

(e) The license, certification and educational requirements for care manager supervisors may be waived for any care manager employed as a care manager prior to December 31, 2016, and applying for the position of care manager supervisor after such date.

10:16?-6.2 General requirements to be an approved provider of JACC services.

(a) To be an approved participant-employed provider (PEP) of JACC services, an individual shall:

1. Possess the following minimum qualifications:

i. Be 18 years of age or older;

ii. Be a United States citizen or a legal alien authorized to work in the United States;

iii. Successfully complete a criminal background investigation;

iv. Be physically capable of rendering the service;

v. Be able to communicate with the participant;

vi. Be capable of reading and writing at a level sufficient to follow written instructions and maintain records required in the performance of duties; and

vii. Understand the need to respect the rights of the participant and the requirement of confidentiality.

2. Meet basic competency standards for the particular service to be provided; and

3. Submit to the participant's care manager an application, with supporting documentation, and demonstrate the ability to render the service.

(b) To be an approved service provider of JACC services, an individual or entity shall submit an application, with supporting documentation, to the Division and submit a renewal application upon request of the Division.

(c) A service provider shall meet the following requirements to be an approved provider:

1. Be legally authorized to conduct business and to render the services in the State;

2. Possess any and all applicable licenses, certifications, registrations, accreditations, qualifications, permits and/or approvals required by law as a precondition to operate a facility and/or render services;

3. Where applicable, utilize employees, workers and contractors who possess any and all licenses, certifications, registrations, accreditations, qualifications, permits and/or approvals required by law as a precondition to operate a facility and/or render services;

4. Maintain proper and adequate insurance coverage at all times, which shall include a minimum of liability insurance and workers' compensation insurance; and

5. Comply with all federal, State and local laws, rules, regulations, codes, policies and procedures in the provision of services under the program.

(d) The Division shall be responsible to determine whether a service provider or PEP meets all requirements and approve the service provider or PEP as a JACC provider.

1. For PEPs, the Division shall send written notification of its decision to the appropriate care management supervisor.

2. For service providers, the Division shall send written notification of its decision to the service provider.

3. No service provider or PEP shall render any JACC service unless and until authorized in writing by the Division to act as a JACC provider.

(e) After receiving approval from the Division, each service provider and PEP shall sign appropriate documentation prior to rendering any JACC service.

1. A PEP shall sign any and all documentation required by the Fiscal Intermediary.

2. A service provider shall sign a written agreement with the Division.

(f) Each service provider and PEP shall notify the Division, in writing, as soon as possible and shall amend the application whenever the information submitted in the application is incorrect or inaccurate.

(g) The Division, in its sole discretion, may deny the application of a service provider or PEP or may revoke the approval of a JACC provider to render JACC services for any of the following reasons:

1. Failure to comply with federal, State or local laws, rules, regulations and codes;

2. Failure to abide by program policies and procedures;

3. Failure to abide by the terms and conditions of the agreement with the Division;

4. Failure to sign documentation and/or agreements as required by the Division in order to render JACC services;

5. Inability to operate or perform the service(s) for which the JACC provider was approved; or

6. The safety and/or well-being of a participant.

10:16?-6.3 Additional requirements for certain service providers.

(a) Adult Day Health services providers. A service provider of Adult Day Health services shall be licensed in accordance with N.J.A.C. 8:43F and shall possess a valid Medicaid provider number for such services.

(b) Chore services providers. A service provider of Chore services shall be a business entity with proof of authority to conduct such business in the State and shall possess literature on business services.

(c) Environmental Accessibility Adaptations services providers. A service provider of Environmental Accessibility Adaptations services shall be a contractor registered with the State.

(d) Home-Delivered Meals services providers. A service provider of Home-Delivered Meal services shall:

1. Be a Title III provider of meal services; or

2. Be a business entity with a commercial recording identification as a food establishment with proof of authority to conduct such business in the State and shall possess literature on business services.

(e) Personal Care Assistant services providers. A service provider of Personal Care Assistant services shall:

1. Be licensed as a Home Health Agency in accordance with N.J.A.C. 8:42; or

2. Be a Homemaker Agency licensed, accredited and registered as a Health Care Service Firm in accordance with N.J.A.C. 13:45B; and

3. Submit to the Division proof that a homemaker or home health aide is a certified home health aide or a personal care assistant in accordance with N.J.A.C. 10:60.

(f) Personal Emergency Response System services providers. A service provider of PERS services shall:

1. Staff its response center with professionals trained in emergency response; and

2. Possess literature on products and services.

(g) Respite Care services providers. A service provider of Respite Care services shall be a facility-based provider or an in-home provider.

1. Facility-Based Respite Care services. A service provider of facility-based Respite Care services shall possess a Medicaid provider number and shall:

i. Be licensed as an assisted living residence, an assisted living program or a comprehensive personal care home in accordance with N.J.A.C. 8:36; or

ii. Be licensed as a long-term care facility in accordance with N.J.A.C. 8:39.

2. In-Home Respite Care services. A service provider of in-home Respite Care services shall:

i. Be licensed as a Home Health Agency in accordance with N.J.A.C. 8:42; or

ii. Be a Homemaker Agency licensed, accredited and registered as a Health Care Service Firm in accordance with N.J.A.C. 13:45B; or

iii. Meet the requirements for a PCA service provider as set forth in subsection (e) above.

(h) Social Adult Day Care services providers. A service provider of Social Adult Day Care services shall:

1. Have police department and fire department response agreements;

2. Have written safety and emergency management policies and procedures;

3. Designate a program director;

4. Have adequate staff to meet the program needs of the target population;

5. Identify a nurse consultant;

6. Develop criteria for the established target population based on resources and program capabilities of the facility;

7. Provide planned and ongoing age-appropriate activities based on social, physical and cognitive needs of the target population;

8. Develop plans of care, in collaboration with each participant and his or her family, based on the identified needs of the participants;

9. Provide coordination with and referrals to available community agencies and services;

10. Have periodic contact with the families of participants;

11. Provide at least one nutritionally balanced meal per day and snacks as necessary;

12. Address special dietary needs of participants;

13. Complete an initial health profile for each participant;

14. Record each participant's weight and, as necessary, other health-related observations on a monthly basis; and

15. Provide participants with personal assistance as needed with mobility and activities of daily living.

(i) Specialized Medical Equipment and Supplies services providers. A service provider of Specialized Medical Equipment and Supplies services shall:

1. Possess a valid Medicaid provider number; or

2. Possess literature on products and services.

(j) Transportation services providers. A service provider of Transportation services shall have and maintain adequate automobile insurance coverage.

SUBCHAPTER 7. PAYMENT TO JACC PROVIDERS

10:16?-7.1 Terms and conditions for payment

(a) The Division shall determine payment rates for the services to be provided under the program.

(b) The Division shall make payment to a JACC provider only for services rendered by the JACC provider after receiving approval and written authorization from the Division to act as a JACC provider.

(c) The Division shall make payment to the JACC provider only for services rendered in accordance with the participant's plan of care and program requirements.

(d) The Division shall make payment to the JACC provider only for the services rendered and at the rate of payment specified in the Individual Service Agreement.

(e) The rates of payment for services shall be as follows:

Service	Unit	Payment Amount	Limitation
Care Management	First month	$200.00	Initial month
Care Management	1 month	$95.00	1/month
Adult Day Health	1 day	Variable, not above Medicaid rate	2/week per ISA
Chore Service	1 job	Usual and	Per ISA

		customary charge ≤ $50.00	
Chore Service – PEP	1 hour	Minimum wage to $9.00/hour	Per ISA
Environmental Accessibility Adaptation	1 job	Usual and customary charge ≤ $500.00, with prior authorization only	Per ISA
Home-Delivered Meals Service	1 meal	Usual and customary charge < $15.00	Per ISA
PCA	1 hour weekday	$15.50	Per ISA
PCA	1 hour weekend or holiday	$17.00	Per ISA
PCA – PEP	1 hour	Minimum wage To $9.00/hour	Per ISA
PCA-Initial Nursing Assessment	1 visit	$35.00	Initial only
PCA – RN Reassessment	1visit	$35.00	Per ISA
Personal Emergency Response System	1 installation	Usual and customary charge < $75.00	Per ISA
Personal Emergency Response System	1 monthly monitoring fee	Usual and customary charge	Per ISA

		≤ $45.00	
Respite Care	8 hour day	$55.00	Per ISA
Respite Care	8 hour night	$65.00	Per ISA
Respite Care	Day time hours, Greater than 8, but less than 12 hours	$80.00	Per ISA
Respite Care	Night time hours, Greater than 8, but less than 12 hours	$90.00	Per ISA
Respite Care	Greater than 12, but less than 24 hours	$100.00	Per ISA
Respite Care	Nursing facility	Variable, not above Medicaid rate	Per ISA
Respite Care	Daily	$50.00	Per ISA
SME & Supplies	1 item	Usual and customary charge at $250.00 a month, with prior authorization only	Per ISA Per ISA
SME & Supplies Evaluation	1 evaluation	≤$50.00	Per ISA
Social Adult Day Care-Traditional Medicaid Employer	1 day	$31.12	3/week per ISA
Social Adult Day Care	1 day	$31.12	3/week per ISA

Transportation	1-one way trip, with expenses as needed	Usual and customary charge ≤ $25.00	Per ISA
	Extra crew differential	Mobile Assistance Vehicle (MAV) only - $10.00	Per ISA
	Oxygen	MAV only - $12.00	Per ISA

(f) The JACC provider shall not receive payment directly from the participant for services rendered under the program.

(g) The JACC provider shall not charge a participant for any services rendered in accordance with the participant's plan of care or for any amount over and above the program rate of reimbursement.

(h) The Division shall not make any payment to a participant.

10:16?-7.2 Procedure for payment

(a) The Division shall provide billing instructions to each approved JACC provider with the notice of approval.

(b) Each JACC provider shall seek payment for services in a timely manner and within the time frame(s) set forth in the billing instructions provided by the Division. The Division, in its sole discretion, may deny payment to a JACC provider for its failure to comply with billing deadlines imposed by the Division.

(c) The Division shall make payment to a JACC provider through the Fiscal Intermediary.

SUBCHAPTER 8. APPEALS

10:16?-8.1 Appeals process

(a) An applicant who is denied enrollment because he or she is not eligible for the program or a participant who has been disenrolled from the program has the right to

request an administrative review conducted by representatives of the Department by submitting a written request to New Jersey Department of Human Services, Division of Aging Services, Jersey Assistance for Community Caregiving Program, PO Box 807, Trenton, New Jersey 08625-0807.

(b) The applicant or participant shall submit the written request to the Division within 20 days of the date of the written adverse action notice. The request shall clearly state the basis for the administrative review and shall include a specific description of each disputed issue arising from the requirements and standards of this chapter.

(c) The applicant or participant shall bear the burden of demonstrating that the decision of the Division deviates from the requirements and/or standards of this chapter.

(d) An applicant or participant who is dissatisfied with the results of the administrative review may appeal the results by requesting a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, within 20 days of the date of the written results of the review if he or she establishes a contested case. The Division shall deny the request for a hearing if the applicant or participant fails to establish a contested case.

(e) The applicant or participant shall submit the written request for a hearing to the address in subsection (a) above.

(f) If the Division determines the matter to be a contested case, the Division shall forward the hearing request to the Office of Administrative Law.