CARE ProviderOne

Client Responsibility

How does the hierarchy work?

The hierarchy is as follows:

1. Payment type
   a. Monthly
   b. Span multiple
   c. Span single
   d. One time
2. Dollar Amount

3. Date & time authorization was submitted

If the payment type is not subject to Client Responsibility (C/R), then that payment type is exempt from the hierarchy and will not be considered.

Why is there a hierarchy?

ProviderOne needs to know in what order to assign C/R. Client will be paying the provider with the largest amount authorized when the multiple providers have the same payment type and their authorizations were submitted on the same day.

How will I know to which provider(s) the C/R will be applied when I am creating the authorized service lines?

Workers will authorize services on or before the first date of service provision. Only when the start date of service is not known should the services be authorized retroactively.

Example 1: The client has no C/R. No C/R will be assigned to the client's authorizations.

Example 2: Two authorizations for the same client were created on the same day. Both are to begin on the first day of the next month. One service code is subject to C/R, the other is not. The client owes $900 in C/R each month. Only the service code subject to C/R will be considered for C/R assignment.

Example 3: Two authorizations for the same client were created on the same day. Both are to begin on the first day of the next month. Both are subject to C/R assignment. The client owes $900 in C/R each month. The cost of care on one authorization is $1000 per month. The cost of care on the other authorization is $50 per month. The authorization which has the cost of care $1000 will have the C/R assigned to it.

Example 4: Two authorizations for the same client were created on the same day. Both are to begin on the first day of the next month. Both are subject to C/R assignment. The client owes $900 in C/R each month. The cost of care on one authorization is $500 per month. The cost of care on the other authorization is $50 per month. The authorization which has the cost of care $500 will have $500 in C/R assigned to it. The authorization which has the cost of care $50 will have $50 in C/R assigned to it. The client has a balance of $350 of C/R which potentially could be assigned to any additional service lines authorized for the same month.

Example 5: An authorization for a service code eligible for C/R assignment was created. The cost of care for this authorization is $50. The client owes $900 in C/R for the month. C/R in the amount of $50 is assigned to this auth. The client has a balance of $850 of C/R still available for assignment. Several days after the month has begun, a new auth is created for a service code eligible for C/R assignment. The cost of care for this auth is $1000. That night, the remaining balance of $850 is assigned to the new auth.

Example 6: Two auths are created on the same day. One auth is in Error status. Both service codes are eligible for C/R assignment. Only the auth in Approved status is considered for C/R assignment.

Example 7: Two auths are created on the same day. One auth is in Error status. Both service codes are eligible for C/R assignment. Client has $900 in C/R each month. Only the auth in Approved status is considered for C/R assignment. There is a remaining balance of $500. Later in the month, the auth which had been in Error status is moved to Approved. That night, the remaining balance of $500 is considered for assignment.

Is (C/R) the same as Participation?

Yes and no, Participation is simply one part of C/R. There are three parts to C/R: Participation (the amount a client participates towards their cost of care), Room and Board (R&B) (only in AFH, EARC, AL, and ARC settings), and Third Party Resources (TPR) (which may include Veterans Affairs benefits, L&I income, Trusts and Long-Term Care insurance). If you have to determine C/R refer to the Client Responsibility section of the SSAM. Social Services Authorization Manual

How will I know the payment type for all of the services?

Payment Type			
1.Monthly	2. Span Multi	3. Span Single	4. One Time
• AFH, ARC, EARC, AL • ECS Add-on (HCS) • PERS • Agency • ADH, ADC • In-home personal care • HDM (HCS) • Durable Medical Equipment (DME) non-blanket codes • Non-medical Equipment & Supplies	• ECS Behavior Support • CCG • Transitional Mental Health • Durable Medical Equipment (DME) blanket codes	• Vision services frames (DDA) • Eyeglasses (DDA)	• Environmental Mod. • Housing Subsidies

Also refer to the service code data sheet (SCDS) that the worker will be using to determine payment type. Service Code Data Sheets (SCDS)

Note: for authorizations created in "Reviewing status" (such as DME and environmental modifications), C/R is not applied until the authorization status is changed to "Approved" after verification the client has received the item or service. Lines in Error status do not have C/R assigned unless/until they are changed to a No Error status.