12VAC30-120-700. Definitions.

"Activities of daily living (ADL)" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. A recipient's degree of independence in performing these activities is a part of determining appropriate level of care and services.

"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the consumer service plan but not available under the State Plan for Medical Assistance that enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live or that are necessary to their proper functioning.

"Attendant care" means long-term maintenance or support services necessary to enable the recipient to remain at or return home rather than enter or remain in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The recipient will be responsible for hiring, training, supervising and firing the personal attendant. If the recipient is unable to independently manage his own attendant care, a family caregiver can serve as the employer on behalf of the recipient. Recipients with cognitive impairments will not be able to manage their own care.

“Behavioral health authority” or “BHA” means the local agency, established by a city or county or combination of counties or cities or cities and counties under §37.1-194 et seq. of the Code of Virginia, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"CARF" means Commission on Accreditation of Rehabilitation Facilities.

“Case manager” means the individual on behalf of the community services board or behavioral health authority staff possessing a combination of mental retardation work experience and relevant education which indicates that the individual possesses the knowledge, skills and abilities, at entry level, as established by the Department of Medical Assistance Services, 12VAC30-50-450. This individual provides case management services as defined in 12 VAC 30-50-440.

"Centers for Medicare and Medicaid Services" or "CMS" means the unit of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.

"Community-based care waiver services" or "waiver services" means the range of community support services approved by the ~~Health Care Financing Administration (HCFA)~~ Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act to be offered to developmentally disabled recipients who would otherwise require the level of care provided in an ICF/MR.

"Community Services Board or CSB" means the local agency established by a city or county or combination of counties or cities, or cities and counties, under § 37.1-194 of the *Code of Virginia*, that plans, provides, and evaluates mental health, mental retardation, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion aide" means, for the purpose of these regulations, a domestic servant who is also exempt from workers' compensation.

"Companion services" means nonmedical care, supervision and socialization, provided to a functionally or cognitively impaired adult. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the consumer service plan. This shall not be the sole service used to divert recipients from institutional care.

"Consumer-directed companion care" means nonmedical care, supervision and socialization provided to a functionally or cognitively impaired adult. The provision of companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the consumer service plan. This shall not be the sole service used to divert recipients from institutional care. The recipient will be responsible for hiring, training, supervising, and firing the ~~personal attendant~~ companion. If the recipient is unable to independently manage his own consumer-directed ~~respite~~ care, a family caregiver can serve as the employer on behalf of the recipient. ~~Recipients with cognitive impairments will not be able to manage their own care.~~

"Consumer-directed respite care" means services given to caretakers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence or need for relief of those persons residing with the recipient who normally provide the care. The recipient will be responsible for hiring, training, supervising, and firing the personal attendant. If the recipient is unable to independently manage his own consumer-directed respite care, a family caregiver can

serve as the employer on behalf of the recipient. ~~Recipients with cognitive impairments will not be able to manage their own care.~~

"Consumer-directed (CD) services facilitator" means the provider contracted by DMAS that is responsible for ensuring development and monitoring of the CSP, management training, and review activities as required by DMAS for attendant care, consumer-directed companion care, and consumer-directed respite care services.

"Consumer service plan" or "CSP" means that document addressing all needs of recipients of home and community-based care developmental disability services, in all life areas. Supporting documentation developed by service providers ~~are~~ is to be incorporated in the CSP by the support coordinator. Factors to be considered when these plans are developed may include, but are not limited to, recipients' ages and levels of functioning.

"Crisis stabilization" means direct intervention to persons with developmental disabilities who are experiencing serious psychiatric or behavioral problems, or both, that jeopardize their current community living situation. This service must provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize recipients and strengthen the current living situations so that recipients can be maintained in the community during and beyond the crisis period.

"Current functional status" means recipients' degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means individuals who perform utilization review, recommendation of preauthorization for service type and intensity, and review of recipient level of care criteria.

"DMHMRSAS" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"DRS" means the Department of Rehabilitative Services.

"DSS" means the Department of Social Services.

"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, services and support activities.

"Environmental modifications" means physical adaptations to a house, place of residence, vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure recipients' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to recipients.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 according to federal guidelines which prescribe specific preventive and treatment services for Medicaid-eligible children.

"Family/caregiver training" means training and counseling services provided to families or caregivers of recipients receiving services in the IFDDS Waiver.

"Fiscal agent" means an agency or organization contracted by DMAS to handle employment, payroll, and tax responsibilities on behalf of recipients who are receiving consumer-directed attendant, respite, and companion services.

"Home" means, for purposes of the IFDDS Waiver, an apartment or single family dwelling in which no more than two individuals who require services live with the exception of siblings living in the same dwelling with family. This does not include an assisted living facility or group home.

"Home and community-based care" means a variety of in-home and community-based services reimbursed by DMAS as authorized under a §1915(c) waiver designed to offer recipients an alternative to institutionalization. Recipients may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/MR placement.

~~"HCFA" means the Health Care Financing Administration, which is the unit of the federal Department of Health and Human Services which administers the Medicare and Medicaid programs.~~

"IFDDS Waiver" means the Individual and Family Developmental Disabilities Support Waiver.

"In-home residential support services" means support provided in the developmentally disabled recipient's home, which includes training, assistance, and supervision in enabling the recipient to maintain or improve his health; assisting in performing recipient care tasks; training in activities of daily living; training and use of community resources; providing life skills training; and adapting behavior to community and home-like environments.

"Instrumental activities of daily living (IADL)" means social tasks (e.g., meal preparation, shopping, housekeeping, laundry, money management). A recipient's degree of independence in performing these activities is part of determining appropriate level of care and services.

"Legal guardian" means a person who has been legally invested with the authority and charged with the duty to take care of, manage the property of, and protect the rights of a recipient who has been declared by the circuit court to be incapacitated and incapable of administering his own affairs. The powers and duties of the guardian are defined by the court and are limited to matters within the areas where the recipient has been determined to be incapacitated.

"Mental retardation" means, as defined by the American Association on Mental Retardation (AAMR), being substantially limited in present functioning as characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests itself before age 18. A diagnosis of mental retardation is made if the person's intellectual functioning level is approximately 70 to 75 or below, as diagnosed by a licensed clinical professional; and there are related limitations in two or more applicable adaptive skill areas; and the age of onset is 18 or below. If a valid IQ score is not possible, significantly subaverage intellectual capabilities means a level of performance that is less than that observed in the vast majority of persons of comparable background. In order to be valid, the assessment of the intellectual performance must be free of errors caused by motor, sensory, emotional, language, or cultural factors.

“MR waiver” means the Mental Retardation waiver.

"Nursing services" means skilled nursing services listed in the consumer service plan which are ordered by a physician and required to prevent institutionalization, not otherwise available under the State Plan for Medical Assistance, are within the scope of the state's Nurse Practice Act (Chapters 30 (§54.1-3000 et seq.) and 34 (§54.1-3400 et seq.) of the Code of Virginia, and are provided by a registered professional nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state.

"Participating provider" means an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS, and has a current, signed contract with DMAS.

"Personal attendant" means, for purposes of this regulation, a domestic servant who is also exempt from Workers' Compensation.

"Personal care agency" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing eligible recipients with personal care aides who provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable recipients to remain in or return to the community rather than enter an Intermediate Care Facility for the Mentally Retarded. Personal care services include assistance with activities of daily living, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes and in the community.

"Personal emergency response system (PERS)" is an electronic device that enables certain recipients at high risk of institutionalization to secure help in an emergency. PERS services are limited to those recipients who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Qualified mental health professional" means a professional having: (i) at least one year of documented experience working directly with recipients who have developmental disabilities; (ii) at least a bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession.

"Related conditions" means those persons who have autism or who have a severe chronic disability that meets all of the following conditions identified in 42 CFR 435.1009:

1. It is attributable to:

a. Cerebral palsy or epilepsy; or

b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self-care.

b. Understanding and use of language.

c. Learning.

d. Mobility.

e. Self-direction.

f. Capacity for independent living.

"Respite care" means services provided to unpaid caretakers of eligible recipients who are unable to care for themselves that is provided on an episodic or routine basis because of the absence of or need for relief of those persons residing with the recipient who normally provide the care.

"Respite care agency" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing respite care services to eligible recipients for their caregivers.

"Screening" means the process to evaluate the medical, nursing, and social needs of recipients referred for screening; determine Medicaid eligibility for an ICF/MR level of care; and authorize Medicaid-funded ICF/MR care or community-based care for those recipients who meet ICF/MR level of care eligibility and require that level of care.

"Screening team" means the entity contracted with DMAS which is responsible for performing screening for the IFDDS Waiver.

"State Plan for Medical Assistance" or "the Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Support coordination" means the assessment, planning, linking, and monitoring for recipients referred for the IFDDS community-based care waiver. Support coordination: (i) ensures the development, coordination, implementation, monitoring, and modification of consumer service plans; (ii) links recipients with appropriate community resources and supports; (iii) coordinates service providers; and (iv) monitors quality of care. Support coordination providers cannot be service providers to recipients in the IFDDS waiver with the exception of consumer-directed service facilitators.

"Supporting documentation" means the specific service plan developed by the recipient service provider related solely to the specific tasks required of that service provider. Supporting documentation helps to comprise the overall CSP for the recipient.

"Supported employment" means training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable a recipient to maintain paid employment.

"Therapeutic consultation" means consultation provided by members of psychology, social work, behavioral analysis, speech therapy, occupational therapy, therapeutic recreation, or physical therapy disciplines or behavior consultation to assist recipients, parents, family members, in-home residential support, day support and any other providers of support services in implementing a CSP.

12VAC30-120-710. General coverage and requirements for all home and community-based care waiver services.

A. Waiver service populations. Home and community-based services shall be available through a §1915(c) waiver. Coverage shall be provided under the waiver for recipients six years of age and older with related conditions as defined in 42 CFR 435.1009, including autism, who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded. The individual must not also have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR). Mental Retardation (MR) Waiver recipients who are six years of age on or after October 1, 2002, who are determined to not have a diagnosis of mental retardation, and meet all IFDDS waiver eligibility criteria, shall be eligible for and transfer to the IFDDS waiver effective with their sixth birthday. Psychological evaluations confirming diagnoses must be completed less than one year prior to the child's sixth birthday. These recipients transferring from the MR waiver will automatically be assigned a slot in the IFDDS waiver. Such slot shall be in addition to those slots available through the screening process described in subsections 12 VAC 30-120-720 C and D.

B. Coverage statement.

1. Covered services shall include in-home residential supports, day support, supported employment, personal care (agency directed), attendant care (consumer directed), respite care (both agency and consumer directed), assistive technology, environmental modifications, nursing services, therapeutic consultation, crisis stabilization, personal emergency response systems (PERS), family/caregiver training, and companion care.

2. These services shall be medically appropriate and necessary to maintain these recipients in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in Intermediate Care Facilities for the

Mentally Retarded under the State Plan that would have been made had the waiver not been granted.

3. Under this §1915(c) waiver, DMAS waives subdivision (a)(10)(B) of §1902 of the Social Security Act related to comparability.

C. Appeals. Recipient appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-380. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-599.

12VAC30-120-720. Recipient qualification and eligibility requirements; intake process.

A. Recipients receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR 435.121 and 435.217. The income level used for 42 CFR 435.121 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person.

1. Under this waiver, the coverage groups authorized under §1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of care criteria. The deeming rules are applied to waiver eligible recipients as if the recipient were residing in an institution or would require that level of care.

2. Virginia shall reduce its payment for home and community-based services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and §1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

a. For recipients to whom §1924(d) applies, and for whom Virginia waives the requirement for comparability pursuant to §1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with a spouse at home, the community spousal income allowance determined in accordance with §1924(d) of the Social Security Act.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with §1924(d) of the Social Security Act.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the Plan.

b. For individuals to whom §1924(d) does not apply and for whom Virginia waives the requirement for comparability pursuant to §1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with a dependent child or children, an additional amount for the maintenance needs of the child or children which shall be equal to the medically needy income standard based on the number of dependent children.

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the state medical assistance plan.

B. Assessment and authorization of home and community-based care services.

1. To ensure that Virginia's home and community-based care waiver programs serve only recipients who would otherwise be placed in an ICF/MR, home and community-based care services shall be considered only for individuals who are eligible for admission to an ICF/MR, absent a diagnosis of mental retardation. Home and community-based care services shall be the critical service that enables the individual to remain at home rather than being placed in an ICF/MR.

2. The recipient's status as an individual in need of IFDDS home and community-based care services shall be determined by the IFDDS screening team after completion of a thorough assessment of the recipient's needs and available support. Screening of home and community-based care services by the IFDDS screening team or DMAS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care services.

3. The IFDDS screening team shall gather relevant medical, social, and psychological data and identify all services received by the recipient. For children to transfer to the IFDDS waiver at age six, case managers shall submit to DMAS the child's most recent Level of Functioning form, the CSP, and a psychological examination completed no more than one year prior to the child's sixth birthday if they are receiving MR waiver services. Such documentation must demonstrate that no diagnosis of mental retardation exists in order for this transfer to the IFDDS waiver to be approved.

4. The case manager shall be responsible for notifying DMAS, DMHMRSAS, and DSS, via the DMAS-122, when a child transfers from the MR waiver to the IFDDS waiver.

~~4.~~ 5. Children under six years of age shall not be screened until three months prior to the month of their sixth birthday. Children under six years of age shall not be added to the waiver/wait list until the month in which their sixth birthday occurs.

~~5.~~ 6. An essential part of the IFDDS screening team's assessment process is determining the level of care required by applying existing DMAS ICF/MR criteria (12VAC30-130-430 et seq.).

~~6.~~ 7. The team shall explore alternative settings and services to provide the care needed by the individual. If placement in an ICF/MR or a combination of other services is determined to be appropriate, the IFDDS screening team shall initiate a referral for service. If Medicaid-funded home and community-based care services are determined to be the critical service to delay or avoid placement in an ICF/MR or promote exiting from an institutional setting, the IFDDS screening team shall initiate a referral for service to a support coordinator of the recipient's choice.

~~7.~~ 8. Home and community-based care services shall not be provided to any individual who also resides in a nursing facility, an ICF/MR, a hospital, an adult family home licensed by the DSS, or an assisted living facility licensed by the DSS.

~~8.~~ 9. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by DMAS. Any Consumer Service Plan for home- and community-based care services must be pre-approved by DMAS prior to Medicaid reimbursement for waiver services.

~~9.~~ 10. The following five criteria shall apply to all IFDDS Waiver services:

a. Individuals qualifying for IFDDS Waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life activities. In order to be eligible, a person must be six years of age or older, have a related condition as defined in these regulations and cannot have a diagnosis of mental retardation, and who would, in the absence of waiver services, require the level of care provided in an ICF/MR facility, the cost of which would be reimbursed under the Plan;

b. The Consumer Service Plan and services that are delivered must be consistent with the Medicaid definition of each service;

c. Services must be approved by the support coordinator based on a current functional assessment tool approved by DMAS or other DMAS approved assessment and demonstrated need for each specific service;

d. Individuals qualifying for IFDDS Waiver services must meet the ICF/MR level of care criteria; and

e. The individual must be eligible for Medicaid as determined by the local office of DSS.

~~10.~~ 11. The IFDDS screening teams must submit the results of the comprehensive assessment and a recommendation to DMAS staff for final determination of ICF/MR level of care and authorization for community-based care services.

C. Screening for the IFDDS Waiver.

1. Individuals requesting IFDDS Waiver services will be screened and will receive services on a first-come, first-served basis in accordance with available funding based on the date the recipients' applications are received. Individuals who meet at least one of the emergency criteria pursuant to 12VAC30-120-790 shall be eligible for immediate access to waiver services if funding is available.

2. To be eligible for IFDDS Waiver services, the individual must:

a. Be determined to be eligible for the ICF/MR level of care;

b. Be six years of age or older,

c. Meet the related conditions definition as defined in 42 CFR 435.1009 or be diagnosed with autism; and

d. Not have a diagnosis of mental retardation as defined by the American Association on Mental Retardation (AAMR) as contained in 12VAC30-120-710.

D. Waiver approval process: available funding.

1. In order to ensure cost effectiveness of the IFDDS Waiver, the funding available for the waiver will be allocated between two budget levels. The budget will be the cost of waiver services only and will not include the costs of other Medicaid covered services. Other Medicaid services, however, must be counted toward cost effectiveness of the IFDDS Waiver. All services available under the waiver are available to both levels.

2. Level one will be for individuals whose comprehensive consumer service plan (CSP) is expected to cost less than $25,000 per fiscal year. Level two will be for individuals whose CSP is expected to cost equal to or more than $25,000. There will not be a threshold for budget level two; however, if the actual cost of waiver services exceeds the average annual cost of ICF/MR care for an individual, the recipient's care will be coordinated by DMAS staff.

3. Fifty-five percent of available waiver funds will be allocated to budget level one, and 40% of available waiver funds will be allocated to level two in order to ensure that the

waiver will be cost effective. The remaining 5.0% of available waiver funds will be allocated for emergencies as defined in 12VAC30-120-790. Recipients who have been placed in budget level one and who subsequently require additional services that would exceed $25,000 per fiscal year must meet the emergency criteria as defined in 12VAC30-120-790 to receive additional funding for services.

E. Waiver approval process: accessing services.

1. Once the screening entity has determined that an individual meets the eligibility criteria for IFDDS Waiver services and the individual has chosen this service, the screening entity will provide the individual with a list of available support coordinators. For MR waiver recipients transferring to the IFDDS waiver, the case manager must provide the recipient or family/caregiver with a list of support coordinators. The individual or family/caregiver will choose a support coordinator within ten calendar days of receiving the list of support coordinators and the screening entity/case manager will forward the screening materials, CSP, and all MR waiver related documentation within ten calendar days of the coordinator's selection to the selected support coordinator.

2. The support coordinator will contact the recipient within 10 calendar days of receipt of screening materials. The support coordinator and the recipient or recipient's family will meet within 30 calendar days to discuss the recipient's needs, existing supports and to develop a preliminary consumer service plan (CSP) which will identify services needed and will estimate the annual waiver cost of the recipient's CSP. If the recipient's annual waiver cost is expected to exceed the average annual cost of ICF/MR care for an individual, the recipient's support coordination will be managed by DMAS.

3. Once the CSP has been initially developed, the support coordinator will contact DMAS to receive prior authorization to enroll the recipient in the IFDDS Waiver. DMAS shall, within 14 days of receiving all supporting documentation, either approve for Medicaid coverage or deny for Medicaid coverage the CSP. DMAS shall only authorize waiver services for the recipient if funding is available for the entire CSP. Once this authorization has been received, the support coordinator shall inform the recipient so that the recipient can begin choosing service providers for services listed in the CSP. If

DMAS does not have the available funding for this recipient, the recipient will be held on the waiting list until such time as funds are available to cover the cost of the CSP.

4. Once the recipient has been authorized for the waiver, the recipient or support coordinator shall contact service providers and initiate services within 60 days. During this time, the consumer, support coordinator, and service providers will meet to complete the CSP. If services are not initiated within 60 days, the support coordinator must submit information to DMAS demonstrating why more time is needed to initiate services. DMAS has authority to approve or deny the request in 30-day extensions. The service providers will develop supporting documentation for each service and will submit a copy of these plans to the support coordinator. The support coordinator will monitor the service providers' supporting documentation to ensure that all providers are working toward the identified goals of recipients. The support coordinator will review and sign off on the supporting documentation and will contact DMAS for prior authorization of services and will notify the service providers when services are approved.

5. The support coordinator will contact the recipient at a minimum on a monthly basis and as needed to coordinate services and maintain the recipient's CSP. DMAS will conduct annual level of care reviews in which the recipient is assessed to ensure he continues to meet waiver criteria. DMAS will review recipients' CSPs and will review the services provided by support coordinators as well as service providers.

CERTIFIED: I certify that this regulation is full, true, and correctly dated.

_____ _____

Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

12VAC30-120-730. General requirements for home and community-based care participating providers.

A. Providers approved for participation shall, at a minimum, perform the following activities:

1. Immediately notify DMAS, in writing, of any change in the information that the provider previously submitted to DMAS.

2. Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid Program at the time the service or services were performed.

3. Assure the recipient's freedom to reject medical care and treatment.

4. Accept referrals for services only when staff is available to initiate services and perform such services on an ongoing basis.

5. Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC §§2000d through 2000d-4a), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (Title 51.5, §51.5-1 et seq. of the Code of Virginia); §504 of the Rehabilitation Act of 1973, as amended (29 USC §794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC §§12101 through 12213), which provides comprehensive civil rights protections to recipients with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

6. Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.

7. Submit charges to DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public. The provider must accept as payment in full the amount established by DMAS payment methodology from the first day of eligibility for the waiver services.

8. Use program-designated billing forms for submission of charges.

9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the care provided.

a. In general, such records shall be retained for at least five years from the last date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia.

c. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and number of hours/units provided (including specific time frame).

10. The provider agrees to furnish information on request and in the form requested to DMAS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the State Medicaid Fraud Control Unit. The Commonwealth's right of access to provider agencies and records shall survive any termination of the provider agreement.

11. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid.

12. Hold confidential and use for DMAS authorized purposes only all medical assistance information regarding recipients served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

13. Change of Ownership. When ownership of the provider agency changes, DMAS shall be notified at least 15 calendar days before the date of change.

14. For (ICF/MR) facilities covered by §1616(e) of the Social Security Act in which respite care as a home and community-based care service will be provided, the facilities shall be in compliance with applicable standards that meet the requirements for board and care facilities. Health and safety standards shall be monitored through the DMHMRSAS' licensure standards, 12VAC35-102-10 et seq.

15. Suspected Abuse or Neglect. Pursuant to §§63.1-55.3 and 63.1-248.3 of the Code of Virginia, if a participating provider knows or suspects that a home and community-based

care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local DSS adult or child protective services worker and to DMAS.

16. Adherence to provider contract and the DMAS provider service manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider contracts and in the DMAS provider manual.

12VAC30-120-740. Participation standards for home and community-based care participating providers.

A. Requests for participation. Requests will be screened to determine whether the provider applicant meets the basic requirements for participation.

B. Provider participation standards. For DMAS to approve contracts with home and community-based care providers, the following standards shall be met:

1. Licensure and certification requirements pursuant to 42 CFR 441.352.

2. Disclosure of ownership pursuant to 42 CFR 455.104 and 455.105.

C. Adherence to provider contract and special participation conditions. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their provider contracts.

D. Recipient choice of provider agencies. The recipient will have the option of selecting the provider agency of his choice.

E. Review of provider participation standards and renewal of contracts. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and recertify each provider for contract renewal with DMAS to provide home and community-based services. A provider's noncompliance with DMAS policies and procedures, as required in the provider's contract, may result in a written request from DMAS for a corrective action plan which details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies which have been cited.

F. Termination of provider participation. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 days' written notification. DMAS

shall be permitted to administratively terminate a provider from participation upon 30 days' written notification. DMAS may also cancel a contract immediately or may give notification in the event of a breach of the contract by the provider as specified in the DMAS contract. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice.

G. Reconsideration of adverse actions. A provider shall have the right to appeal adverse action taken by DMAS. Adverse action includes, but shall not be limited to, termination of the provider agreement by DMAS, and retraction of payments from the provider by DMAS for noncompliance with applicable law, regulation, policy, or procedure. All disputes regarding provider reimbursement or termination of the agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be conducted pursuant to the Virginia Administrative Process Act (§9-6.14:1 et seq. of the Code of Virginia), the State Plan for Medical Assistance provided for in §32.1-325 of the Code of Virginia, and duly promulgated regulations. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

H. Termination of a provider contract upon conviction of a felony. Section 32.1-325 C of the Code of Virginia mandates that "any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington, D.C., must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. Reinstatement will be contingent upon provisions of state law. In addition, termination of a provider contract will occur as may be required for federal financial participation.

I. Support coordinator's responsibility for the Recipient Information Form (DMAS-122). It is the responsibility of the support coordinator to notify DMAS and DSS, in writing, when any of the following circumstances occur:

1. Home and community-based care services are implemented.

2. A recipient dies.

3. A recipient is discharged or terminated from services.

4. Any other circumstances (including hospitalization) that cause home and community-based care services to cease or be interrupted for more than 30 days.

J. Changes or termination of care. It is the DMAS staff's responsibility to authorize any changes to supporting documentation of a recipient's CSP based on the recommendations

of the support coordinator. Agencies providing direct service are responsible for modifying the supporting documentation if the recipient or parent/legal guardian agrees. The provider will submit the supporting documentation to the support coordinator any time there is a change in the recipient's condition or circumstances that may warrant a change in the amount or type of service rendered. The support coordinator will review the need for a change and will sign the supporting documentation if he agrees to the changes. The support coordinator will submit the revised supporting documentation to the DMAS staff to receive approval for that change. The DMAS staff has the final authority to approve or deny the requested change to recipients' supporting documentation.

1. Nonemergency termination of home and community-based care services by the participating provider. The participating provider shall give the recipient and family and support coordinator 10 days' written notification of the intent to terminate services. The letter shall provide the reasons for and effective date of the termination. The effective date of services termination shall be at least 10 days from the date of the termination notification letter.

2. Emergency termination of home and community-based care services by the participating provider. In an emergency situation when the health and safety of the recipient or provider agency personnel is endangered, the support coordinator and DMAS must be notified prior to termination. The 10-day written notification period shall not be required. If appropriate, the local DSS adult protective services or child protective services agency must be notified immediately.

3. The DMAS termination of eligibility to receive home and community-based care services. DMAS shall have the ultimate responsibility for assuring appropriate placement of the recipient in home and community-based care services and the authority to terminate such services to the recipient for the following reasons:

a. The home and community-based care service is not the critical alternative to prevent or delay institutional (ICF/MR) placement;

b. The recipient no longer meets the institutional level of care criteria;

c. The recipient's environment does not provide for his health, safety, and welfare; or

d. An appropriate and cost-effective CSP cannot be developed.

Article 2
Covered Services and Limitations and Related Provider Requirements

12VAC30-120-750. In-home residential support services.

A. Service description. In-home residential support services shall be based in the recipient's home. The service shall be designed to enable recipients qualifying for the IFDDS Waiver to be maintained in their homes and shall include: (i) training in or reinforcement of functional skills and appropriate behavior related to a recipient's health and safety, personal care, activities of daily living and use of community resources; (ii) assistance with medication management and monitoring the recipient's health, nutrition, and physical condition; (iii) life skills training; (iv) cognitive rehabilitation; and (v) assistance with personal care activities of daily living and use of community resources. Service providers shall be reimbursed only for the amount and type of in-home residential support services included in the recipient's approved CSP. In-home residential support services shall not be authorized in the CSP unless the recipient requires these services and these services exceed services provided by the family or other caregiver. Services will not be provided for a continuous 24-hour period.

1. This service must be provided on a recipient-specific basis according to the CSP, supporting documentation, and service setting requirements.

2. This service may not be provided to any recipient who simultaneously receives personal care or attendant care services under the IFDDS Waiver or other residential program that provides a comparable level of care.

3. Room and board and general supervision shall not be components of this service.

4. This service shall not be used solely to provide routine or emergency respite care for the parent or parents or other caregivers with whom the recipient lives.

B. Criteria.

1. All recipients must meet the following criteria in order for Medicaid to reimburse for in-home residential support services. The recipient must meet the eligibility requirements for this waiver service as herein defined. The recipient shall have a demonstrated need for supports to be provided by staff who are paid by the in-home residential support provider.

2. A functional assessment must be conducted to evaluate each recipient in his home environment and community settings.

3. Routine supervision/oversight of direct care staff. To provide additional assurance for the protection or preservation of a recipient's health and safety, there are specific requirements for the supervision and oversight of direct care staff providing residential support as outlined below. For all in-home residential support services provided under a DMHMRSAS license:

a. An employee of the agency, typically by position, must be formally designated as the supervisor of each direct care staff person who is providing in-home residential support services.

b. The supervisor must have and document at least one supervisory contact per month with each staff person regarding service delivery and staff performance.

c. The supervisor must observe each staff person delivering services at least semi-annually. Staff performance and service delivery according to the CSP should be documented, along with evaluation and evidence of recipient satisfaction with service delivery by staff.

d. Providers of in-home residential supports must also have and document at least one monthly contact with the recipient regarding satisfaction with services delivered by each staff person. If the recipient has a guardian, the guardian should be contacted.

4. The in-home residential support supporting documentation must indicate the necessary amount and type of activities required by the recipient, the schedule of residential support services, the total number of hours per day, and the total number of hours per week of in-home residential support.

5. Medicaid reimbursement is available only for in-home residential support services provided when the recipient is present and when a qualified provider is providing the services.

C. Service units and service limitations. In-home residential supports shall be reimbursed on an hourly basis for time the in-home residential support staff is working directly with the recipient. Total monthly billing cannot exceed the total hours authorized in the CSP. The provider must maintain documentation of the date and times that the services are provided, services that were provided, and specific circumstances which prevented provision of all of the scheduled services.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, each in-home residential support service provider must be licensed by DMHMRSAS as a provider of supportive residential services or have CARF certification. The provider must also have training in the characteristics of

developmental disabilities and appropriate interventions, strategies, and support methods for persons with developmental disabilities and functional limitations.

1. For DMHMRSAS licensed programs, a CSP and ongoing documentation must be consistent with licensing regulations.

2. Documentation must confirm attendance and the amount of time in services and provide specific information regarding the recipient's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results must be available in at least a daily note or a weekly summary. Data must be collected as described in the CSP, analyzed, summarized, and then clearly addressed in the regular supporting documentation.

3. The supporting documentation must be reviewed by the provider with the recipient, and this review submitted to the support coordinator, at least semi-annually, with goals, objectives, and activities modified as appropriate.

4. Documentation must be maintained for routine supervision and oversight of all in-home residential support staff. All significant contacts described in this section must be documented.

5. Documentation must be completed and signed by the staff person designated to perform the supervision and oversight and include:

a. Date of contact or observation;

b. Person or persons contacted or observed;

c. A note regarding staff performance and supporting documentation service delivery for monthly contact and semi-annual home visits;

d. Semi-annual observation documentation must also address recipient satisfaction with service provision; and

e. Any action planned or taken to correct problems identified during supervision and oversight.

12VAC30-120-752. Day support services.

A. Service description. Day support services shall include a variety of training, support, and supervision offered in a setting (other than the home or recipient residence), which

allows peer interactions and community integration. When services are provided through alternative payment sources, the consumer service plan shall not authorize them as a waiver funded expenditure. Service providers are reimbursed only for the amount and type of day support services included in the recipient's approved CSP based on the setting, intensity, and duration of the service to be delivered.

B. Criteria. For day support services, recipients must demonstrate the need for functional training, assistance, and specialized training offered in settings other than the recipient's own residence that allow an opportunity for being productive and contributing members of communities. In addition, day support services will be available for recipients who cannot benefit from supported employment services and who need the services for accessing in-home supported living services, increasing levels of independent skills within current daily living situations, or sustaining skills necessary for continuing the level of independence in current daily living situations.

1. A functional assessment should be conducted by the provider to evaluate each recipient in his home environment and community settings.

2. Levels of day support. The amount and type of day support included in the recipient's consumer service plan is determined according to the services required for that recipient. There are two types of day support: center-based, which is provided partly or entirely in a segregated setting; or noncenter-based, which is provided entirely in community settings. Both types of day support may be provided at either intensive or regular levels. To be authorized at the intensive level, the recipient must have extensive disability-related difficulties and require additional, ongoing support to fully participate in programming and to accomplish his service goals; or the recipient requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

C. Service units and service limitations. Day support cannot be regularly or temporarily (e.g., due to inclement weather or recipient illness) provided in a recipient's home or other residential setting without written prior approval from DMAS. If prevocational services are offered, the plan of care must contain documentation regarding whether prevocational services are available in vocational rehabilitation agencies through §110 of the Rehabilitation Act of 1973 or in Special Education services through §602 (16) and (17) of the Individuals with Disabilities Act. When services are provided through these sources, the plan of care shall not authorize them as a waiver expenditure. Compensation for prevocational services can only be made when the individual's productivity is less than 50% of the minimum wage. Noncenter-based day support services must be separate and distinguishable from either in-home residential support services or personal care services. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The

supporting documentation must provide an estimate of the amount of day support required by the recipient. The maximum is 780 units per calendar year. Transportation shall not be billable as a day support service.

1. One unit shall be 1 to 3.99 hours of service a day.

2. Two units are 4 to 6.99 hours of service a day.

3. Three units are 7 or more hours of service a day.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, day support providers need to meet additional requirements.

1. For DMHMRSAS programs licensed as day support programs, the CSP, supporting documentation, and ongoing documentation must be consistent with licensing regulations. For programs certified by CARF as day support programs, there must be supporting documentation, which contains at a minimum, the following elements:

a. The recipient's strengths, desired outcomes, required or desired supports and training needs;

b. The recipient's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

d. All individuals or organizations that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the recipient's goals and objectives;

f. The estimated duration of the recipient's needs for services; and

g. The individual or individuals responsible for the overall coordination and integration of the services specified in the CSP.

2. Documentation must confirm the recipient's attendance and amount of time in services and provide specific information regarding the recipient's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results shall be available in at least a daily note or a weekly summary.

a. The supporting documentation must be reviewed by the provider with the recipient, and this review submitted to the support coordinator at least semi-annually with goals, objectives, and activities modified as appropriate.

b. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units provided (including specific time frame).

c. Documentation must indicate whether the services were center-based or noncenter-based.

d. If intensive day support services are requested, in order to verify which of these criteria the recipient met, documentation must be present in the recipient's record to indicate the specific supports and the reasons they are needed. For reauthorization of intensive day support services, there must be clear documentation of the ongoing needs and associated staff supports.

12VAC30-120-754. Supported employment services.

A. Service description.

1. Supported employment services shall include training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized training to enable a recipient to maintain paid employment. Each supporting documentation must contain documentation regarding whether supported employment services are available in vocational rehabilitation agencies through the Rehabilitation Act of 1973 or in special education services through 20 USC §1401 of the Individuals with Disabilities Education Act (IDEA). Providers of these DRS and IDEA services cannot be reimbursed by Medicaid with the IFDDS Waiver funds. Waiver service providers are reimbursed only for the amount and type of habilitation services included in the recipient's approved CSP based on the intensity and duration of the service delivered. Reimbursement shall be limited to actual interventions by the provider of supported employment, not for the amount of time the recipient is in the supported employment environment.

2. Supported employment can be provided in one of two models. Recipient supported employment is defined as intermittent support, usually provided one on one by a job coach to a recipient in a supported employment position. Group supported employment is defined as continuous support provided by staff to eight or fewer recipients with disabilities in an enclave, work crew, or bench work/entrepreneurial model. The recipient's assessment and CSP must clearly reflect the recipient's need for training and supports.

B. Criteria for receipt of services.

1. Only job development tasks that specifically include the recipient are allowable job search activities under the IFDDS Waiver supported employment and only after determining this service is not available from DRS.

2. In order to qualify for these services, the recipient shall have a demonstrated need for training, specialized supervision, or assistance in paid employment and for whom competitive employment at or above the minimum wage is unlikely without this support and who, because of the disability, needs ongoing support, including supervision, training and transportation to perform in a work setting.

3. A functional assessment should be conducted to evaluate each recipient in his home environment and community settings.

4. The supporting documentation must provide the amount of supported employment required by the recipient. Service providers are reimbursed only for the amount and type of supported employment included in the recipient's CSP.

C. Service units and service limitations.

1. Supported employment for recipient job placement will be billed on an hourly basis. Transportation cannot be billable as a supported employment service.

2. Group models of supported employment (enclaves, work crews and entrepreneurial model of supported employment) will be billed at the unit rate.

a. One unit is 1 to 3.99 hours of service a day.

b. Two units are 4 to 6.99 or more hours of service a day.

c. Three units are 7 or more hours of service a day.

3. For the recipient job placement model, reimbursement of supported employment will be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the recipient is in the supported employment situation.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, specific provider qualifications are as follows:

1. Supported employment services shall be provided by agencies that are programs certified by CARF to provide supported employment services or are DRS vendors of supported employment services.

2. Recipient ineligibility for supported employment services through DRS or Special Education services must be documented in the recipient's record, as applicable. If the recipient is older than 22 years and, therefore, not eligible for Special Education funding, documentation is required only for lack of DRS funding. Acceptable documentation would include a copy of a letter from DRS or the local school system or a record of a phone call (name, date, person contacted) documented in the support coordinator's case notes, Consumer Profile/Social assessment or on the supported employment supporting documentation. Unless the recipient's circumstances change, the original verification can be forwarded into the current record or repeated on the supporting documentation or revised Consumer Profile/Social Assessment on an annual basis.

3. Supporting documentation and ongoing documentation consistent with licensing regulations, if a DMHMRSAS licensed program.

4. For non-DMHMRSAS programs certified as supported employment programs, there must be supporting documentation that contains, at a minimum, the following elements:

a. The recipient's strengths, desired outcomes, required/desired supports and training needs;

b. The recipient's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

d. All individuals or organizations that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the recipient's goals and objectives;

f. The estimated duration of the recipient's needs for services; and

g. Individuals responsible for the overall coordination and integration of the services specified in the plan.

5. Documentation must confirm attendance and provide specific information regarding the recipient's response to various settings and supports as agreed to in the supporting

documentation objectives. Assessment results should be available in at least a daily note or weekly summary.

6. The supporting documentation must be reviewed by the provider with the recipient, and this review submitted to the support coordinator, at least semi-annually, with goals, objectives and activities modified as appropriate.

12VAC30-120-756. Therapeutic consultation.

A. Service description. Therapeutic consultation is available under the waiver for Virginia licensed or certified practitioners in psychology, social work, occupational therapy, physical therapy, therapeutic recreation, rehabilitation, and speech/language therapy. Behavior consultation performed by these individuals may also be a covered waiver service. These services may be provided, based on the recipient's CSP, for those recipients for whom specialized consultation is clinically necessary to enable their utilization of waiver services. Therapeutic consultation services may be provided in in-home residential or day support settings or in office settings in conjunction with another waiver service. Only behavior consultation may be offered in the absence of any other waiver service when the consultation provided to informal caregivers is determined to be necessary to prevent institutionalization. Therapeutic consultation service providers are reimbursed according to the amount and type of service authorized in the CSP based on an hourly fee for service.

B. Criteria. In order to qualify for these services, the recipient shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the CSP cannot be implemented effectively and efficiently without such consultation from this service.

1. The recipient's CSP must clearly reflect the recipient's needs, as documented in the social assessment, for specialized consultation provided to caregivers in order to implement the CSP effectively.

2. Therapeutic consultation services may neither include direct therapy provided to waiver recipients nor duplicate the activities of other services that are available to the recipient through the State Plan of Medical Assistance.

C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the supporting documentation. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, professionals rendering therapeutic consultation services, including behavior consultation services, shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation consultation shall be rehabilitation engineers or certified rehabilitation specialists.

1. Supporting documentation for therapeutic consultation. The following information is required in the supporting documentation:

a. Identifying information: recipient's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for supporting documentation; and semi-annual review dates, if applicable;

b. Targeted objectives, time frames, and expected outcomes;

c. Specific consultation; and

d. The expected outcomes.

2. Monthly and contact notes shall include:

a. Summary of consultative activities for the month;

b. Dates, locations, and times of service delivery;

c. Supporting documentation objectives addressed;

d. Specific details of the activities conducted;

e. Services delivered as planned or modified; and

f. Effectiveness of the strategies and recipients' and caregivers' satisfaction with service.

3. Semi-annual reviews are required by the service provider if consultation extends three months or longer, are to be forwarded to the support coordinator, and must include:

a. Activities related to the therapeutic consultation supporting documentation;

b. Recipient status and satisfaction with services; and

c. Consultation outcomes and effectiveness of support plan.

4. If consultation services extend less than three months, the provider must forward monthly contact notes or a summary of them to the support coordinator for the semi-annual review.

5. A written support plan, detailing the interventions and strategies for staff, family, or caregivers to use to better support the recipient in the service.

6. A final disposition summary must be forwarded to the support coordinator within 30 days following the end of this service and must include:

a. Strategies utilized;

b. Objectives met;

c. Unresolved issues; and

d. Consultant recommendations.

12VAC30-120-758. Environmental modifications.

A. Service description. Environmental modifications shall be available to recipients who are receiving at least one other waiver service. Environmental modifications shall be defined as those physical adaptations to the home, required by the individual's CSP, that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual to function with greater independence in the home and, without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repairs, central air conditioning, etc. Adaptations that add to the total square footage of the home shall be excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Modifications can be made to a vehicle if it is the primary vehicle being used by the individual.

B. Criteria. In order to qualify for these services, the recipient must have a demonstrated need for equipment or modifications of a remedial or medical benefit offered primarily in a recipient's home, vehicle, community activity setting, or day program to specifically improve the recipient's personal functioning. This service shall encompass those items

not otherwise covered in the State Plan for Medical Assistance or through another program.

C. Service units and service limitations. A maximum limit of $5,000 may be reimbursed per calendar year. Costs for environmental modifications shall not be carried over from year to year. All environmental modifications must be prior authorized by DMAS.

D. Provider requirements. In addition to meeting the general conditions and requirements for HCBC participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, environmental modifications must be provided in accordance with all applicable state or local building codes by contractors who have a provider agreement with DMAS.

12VAC30-120-760. Skilled nursing services.

A. Service description. Skilled nursing services shall be provided for recipients with serious medical conditions and complex health care needs who require specific skilled nursing services that cannot be provided by non-nursing personnel. Skilled nursing may be provided in the recipient's home or other community setting on a regularly scheduled or intermittent need basis.

B. Criteria. In order to qualify for these services, the recipient must demonstrated complex health care needs that require specific skilled nursing services ordered by a physician and that cannot be otherwise accessed under the Title XIX State Plan for Medical Assistance. The recipient's CSP must stipulate that this service is necessary in order to prevent institutionalization.

C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in hourly units.

D. Provider requirements. Skilled nursing services shall be provided by either a DMAS enrolled private duty nursing, a home health provider, or a licensed registered nurse or licensed practical nurse contracted or employed by a Community Services Board. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, in order to be approved for skilled nursing contracts, the provider must:

1. If a home health agency, be certified by the VDH for Medicaid participation and have a DMAS contract for private duty nursing;

2. Demonstrate a prior successful health care delivery business or practice;

3. Operate from a business office; and

4. If community services boards employ or subcontract with and directly supervise a registered nurse (RN) or a licensed practical nurse (LPN) with a current and valid license issued by the Virginia State Board of Nursing, the RN or LPN must have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, or nursing home.

12VAC30-120-762. Assistive technology.

A. Service description. Assistive technology (AT) is available to recipients who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting.

B. Criteria. In order to qualify for these services, the recipient must have a demonstrated need for equipment or modification for remedial or medical benefit primarily in a recipient's home, vehicle, community activity setting, or day program to specifically serve to improve the recipient's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. Assistive technology shall be covered in the least expensive, most cost-effective manner.

C. Service units and service limitations. A maximum limit of $5,000 may be reimbursed per calendar year. Costs for assistive technology cannot be carried over from year to year. AT will not be approved for purposes of convenience or restraint. An independent consultation must be obtained for each AT request prior to approval by DMAS. All assistive technology must be prior authorized by DMAS.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, assistive technology shall be provided by agencies under contract with DMAS as durable medical equipment and supply providers. Independent consultants shall be speech/language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers.

12VAC30-120-764. Crisis stabilization services.

A. Service description. Crisis stabilization services shall provide, as appropriate, neuropsychological, psychiatric, psychological and functional assessments and

stabilization, medication management and behavior assessment and support, and intensive care coordination with other agencies and providers. These services shall be provided to:

1. Assist planning and delivery of services and supports to maintain community placement of the recipient;

2. Train family members and other care givers and service providers in positive behavioral supports to maintain the recipient in the community; and

3. Provide temporary crisis supervision to ensure the safety of the recipient and others;

B. Criteria.

1. In order to receive crisis stabilization services, the recipient must meet at least one of the following criteria:

a. The recipient is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;

b. The recipient is experiencing extreme increase in emotional distress;

c. The recipient needs continuous intervention to maintain stability; or

d. The recipient is causing harm to self or others.

2. The recipient must be at risk of at least one of the following:

a. Psychiatric hospitalization;

b. Emergency ICF/MR placement;

c. Disruption of community status (living arrangement, day placement, or school); or

d. Causing harm to self or others.

C. Service units and service limitations. Crisis stabilization services must be authorized following a documented face-to-face assessment conducted by a qualified mental health professional.

1. The unit for each component of the service is one hour. This service may be authorized in 15-day increments, but no more than 60 days in a calendar year may be used. The actual service units per episode shall be based on the documented clinical needs of the

recipients being served. Extension of services beyond the 15-day limit per authorization must be authorized following a documented face-to-face reassessment conducted by a qualified professional.

2. Crisis stabilization services may be provided directly in the following settings (the following examples are not exclusive):

a. The home of a recipient who lives with family or other primary caregiver or caregivers;

b. The home of a recipient who lives independently or semi-independently to augment any current services and support;

c. A day program or setting to augment current services and supports; or

d. A respite care setting to augment current services and supports.

3. Crisis supervision may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided face-to-face with the recipient.

4. Crisis stabilization services shall not be used for continuous long-term care. Room and board and general supervision are not components of this service.

D. Provider requirements. In addition to the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, the following specific provider qualifications apply:

1. Crisis stabilization services shall be provided by agencies licensed by DMHMRSAS as a provider of outpatient, residential, supportive residential services, or day support services. The provider agency must employ or utilize qualified licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and related activities to recipients with developmental disabilities who are experiencing serious behavioral problems.

2. Crisis stabilization supporting documentation must be developed (or revised, in the case of a request for an extension) and submitted to the support coordinator for authorization within 72 hours of assessment or reassessment.

3. Documentation indicating the dates and times of crisis stabilization services and amount and type of service provided must be recorded in the recipient's record.

4. Documentation of qualifications of providers must be maintained for review by DMAS staff. This service shall be designed to stabilize the recipient and strengthen the current

semi-independent living situation, or situation with family or other primary care givers, so the recipient can be maintained during and beyond the crisis period.

12VAC30-120-766. Personal care services.

A. Service description. Personal care services may be offered to recipients in their homes and communities as an alternative to more costly institutional care. This service shall provide care to recipients with activities of daily living, medication or other medical needs or the monitoring of health status or physical condition. Recipients shall be permitted to share service hours for no more than two individuals living in the same home.

B. Criteria. In order to qualify for these services, the individual must demonstrate a need for such personal care.

C. Service units and service limitations. Recipients can have personal care and in-home residential support services in their service plan but cannot receive in-home residential supports and personal care services at the same time. Each recipient must have an emergency back-up plan in case the personal care aide does not show up for work as expected.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, personal care providers must meet additional provider requirements.

1. Personal care services shall be provided by a DMAS certified personal care provider or by a DMHMRSAS licensed residential support provider.

2. The personal care provider must:

a. Demonstrate a prior successful health care delivery business.

b. Operate from a business office.

c. Employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all personal care aides.

(1) The supervising RN and LPN must be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience that

may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.

(2) The RN supervisor must make an initial assessment comprehensive home visit prior to the start of care for all new recipients admitted to personal care. The RN supervisor must also perform any subsequent reassessments or changes to the supporting documentation.

(3) The RN or LPN must make supervisory visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 to 90 days depending on recipient needs.

(4) The supervising RN or LPN summary must note:

(a) Whether personal care services continue to be appropriate;

(b) Whether the plan is adequate to meet the need or if changes are indicated in the plan;

(c) Any special tasks performed by the aide and the aide's qualifications to perform these tasks;

(d) Recipient's satisfaction with the service;

(e) Hospitalization or change in medical condition or functioning status;

(f) Other services received and their amount; and

(g) The presence or absence of the aide in the home during the RN's or LPN's visit.

(5) Employ and directly supervise personal care aides who will provide direct care to personal care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by DMAS. Each aide must:

(a) Be able to read and write;

(b) Have completed 40 hours of training consistent with the DMAS standards. Prior to assigning an aide to a recipient, the provider agency must ensure that the aide has satisfactorily completed a training program consistent with DMAS standards;

(c) Be physically able to do the work;

(d) Have a satisfactory work record as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children; and

(e) Not be a member of the recipient's family (family is defined as parents of minor children, spouses, or legally responsible relatives. Payment will not be made for services furnished by other family members unless there is objective written documentation as to why there are no other providers available to provide the care.

3. Provider inability to render services and substitution of aides.

a. When a personal care aide is absent and the agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients. The agency may either obtain a substitute aide from another agency if the lapse in coverage is to be less than two weeks in duration, or transfer the recipient to another agency.

b. During temporary, short-term lapses in coverage not to exceed two weeks in duration, the following procedures must apply:

(1) The personal care agency having recipient responsibility must provide the RN or LPN supervision for the substitute aide.

(2) The agency providing the substitute aide must send a copy of the aide's signed daily records signed by the recipient to the personal care agency having recipient care responsibility.

(3) The provider agency having recipient responsibility must bill DMAS for services rendered by the substitute aide.

c. If a provider agency secures a substitute aide, the provider agency is responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS' requirements.

4. Required documentation in recipients' records. The provider agency must maintain all records of each personal care recipient. At a minimum these records must contain:

a. The most recently updated CSP and supporting documentation, all provider agency documentation, and all DMAS-122 forms;

b. All the DMAS utilization review forms;

c. Initial assessment by the RN supervisory nurse completed prior to or on the date services are initiated and subsequent reassessments and changes to supporting documentation by the RN supervisory nurse;

d. Nurses notes recorded and dated during any contacts with the personal care aide and during supervisory visits to the recipient's home;

e. All correspondence to the recipient and to DMAS;

f. Reassessments made during the provision of services; and

g. Contacts made with family, physicians, DMAS, formal and informal service providers, and all professionals concerning the recipient.

h. All personal care aide records. The personal care aide record must contain:

(1) The specific services delivered to the recipient by the aide and the recipient's responses;

(2) The aide's arrival and departure times;

(3) The aide's weekly comments or observations about the recipient to include observations of the recipient's physical and emotional condition, daily activities, and responses to services rendered; and

(4) The aide's and recipient's weekly signatures to verify that personal care services during that week have been rendered.

i. Signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

12VAC30-120-768. Respite care services.

A. Service description. Respite care means services specifically designed to provide a temporary but periodic or routine relief to the unpaid primary caregiver of a recipient who is incapacitated or dependent due to physical or cognitive disability. Respite care services include assistance with personal hygiene, nutritional support, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver. Persons can have respite care and in-home residential support services in their service plan but cannot receive in-home residential supports and respite care services simultaneously.

B. Criteria. Respite care may only be offered to recipients who have a primary unpaid caregiver living in the home who requires temporary relief to avoid institutionalization of the recipient. Respite care is designed to focus on the need of the caregiver for temporary relief and to help prevent the breakdown of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the dependent recipient.

C. Service units and service limitations. Respite care services are limited to a maximum of 30 days or 720 hours per year.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, providers must meet the following qualifications:

1. Respite care services shall be provided by a DMAS certified personal care provider, a DMHMRSAS licensed supportive in-home residential support provider, respite care services provider (ICF/MR), or in-home respite care provider.

2. The respite care provider must employ or subcontract with and directly supervise an RN or an LPN who will provide ongoing supervision of all respite care aides.

a. The RN and LPN must be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience, which may include work in an acute care hospital, public health clinic, home health agency, or nursing facility.

b. Based on continuing evaluations of the aides' performances and recipients' needs, the RN or LPN supervisor shall identify any gaps in the aides' abilities to function competently and shall provide training as indicated.

c. The RN supervisor must make an initial assessment visit prior to the start of care for any recipient admitted to respite care. The RN supervisor must also perform any subsequent reassessments or changes to the supporting documentation.

d. The RN or LPN must make supervisory visits as often as needed to ensure both quality and appropriateness of services.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of these supervisory visits shall be every 30 to 90 days.

(2) When respite care services are not received on a routine basis, but are episodic in nature, the RN or LPN is not required to conduct a supervisory visit every 30 to 90 days. Instead, the nurse supervisor must conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period.

(3) When respite care services are routine in nature and offered in conjunction with personal care, the 30 to 90 day supervisory visit conducted for personal care may serve as the RN or LPN visit for respite care. However, the RN or LPN supervisor must document supervision of respite care separately. For this purpose, the same recipient record can be used with a separate section for respite care documentation.

e. The RN or LPN must document in a summary note:

(1) Whether respite care services continue to be appropriate.

(2) Whether the supporting documentation is adequate to meet the recipient's needs or if changes need to be made.

(3) The recipient's satisfaction with the service.

(4) Any hospitalization or change in medical condition or functioning status.

(5) Other services received and the amount.

(6) The presence or absence of the aide in the home during the visit.

3. Employ and directly supervise respite care aides who provide direct care to respite care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications. Each aide must:

a. Be able to read and write;

b. Have completed 40 hours of training consistent with the DMAS standards. Prior to assigning an aide to a recipient, the provider agency must ensure that the aide has satisfactorily completed a training program consistent with the DMAS standards;

c. Be evaluated in his job performance by the RN or LPN supervisor;

d. Be physically able to do the work;

e. Have a satisfactory work record as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect or exploitation of aged or incapacitated adults or children; and

f. Not be a member of a recipient's family (family is defined as parents of minor children, spouses, or legally responsible relatives. Payment will not be made for services furnished by other family members unless there is objective written documentation as to why there are no other providers available to provide the care.

4. Inability to provide services and substitution of aides. When a respite care aide is absent and the respite care provider agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients.

a. If a provider agency cannot supply a respite care aide to render authorized services, the agency may either obtain a substitute aide from another agency if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient's care to another agency.

b. If no other provider agency is available who can supply an aide, the provider agency shall notify the recipient or family so that they may contact the support coordinator to request a screening if ICF/MR placement is desired.

c. During temporary, short-term lapses in coverage, not to exceed two weeks in duration, a substitute aide may be secured from another respite care provider agency or other home care agency. Under these circumstances, the following requirements apply:

(1) The respite care agency having recipient responsibility is responsible for providing the RN or LPN supervision for the substitute aide.

(2) The respite care agency having recipient care responsibility must obtain a copy of the aide's daily records signed by the recipient and the substitute aide from the respite care agency providing the substitute aide. All documentation of services rendered by the substitute aide must be in the recipient's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the personnel files of the agency having recipient care responsibility. The two agencies involved are responsible for negotiating the financial arrangements of paying the substitute aide.

(3) Only the provider agency having recipient responsibility may bill DMAS for services rendered by the substitute aide.

d. Substitute aides obtained from other agencies may be used only in cases where no other arrangements can be made for recipient respite care services coverage and may be used only on a temporary basis. If a substitute aide is needed for more than two weeks, the case must be transferred to another respite care provider agency that has the aide capability to serve the recipient or recipients.

5. Required documentation for recipients' records. The provider agency must maintain all records of each respite care recipient. These records must be separated from those of other nonwaiver services, such as home health services. These records will be reviewed periodically by the DMAS staff. At a minimum these records must contain:

a. The most recent CSP and supporting documentation, all respite care assessments, and all DMAS-122 forms;

b. All DMAS utilization review forms;

c. Initial assessment by the RN supervisory nurse completed prior to or on the date services are initiated and subsequent reassessments and changes to supporting documentation by the RN supervisory nurse;

d. Nurses' notes recorded and dated during significant contacts with the respite care aide and during supervisory visits to the recipient's home;

e. All correspondence to the recipient and to DMAS;

f. Reassessments made during the provision of services; and

g. Significant contacts made with family, physicians, DMAS, and all professionals concerning the recipient.

6. Respite care aide record of services rendered and recipient's responses. The aide record must contain:

a. The specific services delivered to the recipient by the respite care aide and the recipient's response.

b. The arrival and departure time of the aide for respite care services only.

c. Comments or observations recorded weekly about the recipient. Aide comments must include, at a minimum, observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to services rendered.

d. The signature of the aide and the recipient once each week to verify that respite care services have been rendered.

e. Signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

7. Copies of all aide records shall be subject to review by state and federal Medicaid representatives.

12VAC30-120-770. Consumer-directed services: attendant care, companion care, and respite care.

A. Service definition.

1. a. Attendant services include hands-on care specific to the needs of a recipient. Attendant care includes assistance with ADLs, bowel/bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. When specified, supportive services may include assistance with instrumental activities of daily living (IADLs) that are incidental to the care furnished, or that are essential to the health and welfare of the recipient. Attendant care does not include either practical or professional nursing services or those practices regulated in Chapters 30 (§54.1-3000 et seq.) and 34 (§54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, as appropriate. Recipients can have attendant care and in-home residential support services in their service plan but cannot receive these two services simultaneously.

b. An additional component to attendant care will be work-related attendant services. This service will extend the ability of the personal attendant to provide assistance in the workplace. These services include filing, retrieving work materials that are out of reach, providing travel assistance for a consumer with a mobility impairment, helping a consumer with organizational skills, reading handwritten mail to a consumer with a visual impairment, or ensuring that a sign language interpreter is present during staff meetings to accommodate an employee with a hearing impairment.

2. Consumer-directed respite care means services specifically designed to provide a temporary but periodic or routine relief to the primary unpaid caregiver of a recipient who is incapacitated or dependent due to frailty or physical disability. Respite care services includes assistance with personal hygiene, nutritional support, and environmental maintenance authorized as either episodic, temporary relief, or as a routine periodic relief of the caregiver.

3. Companion care is a covered service when its purpose is to supervise or monitor those individuals who require the physical presence of an aide to insure their safety during times when no other supportive individuals are available.

4. DMAS shall contract for the services of a fiscal agent for attendant care, companion care, and consumer-directed respite care services. The fiscal agent will be reimbursed by DMAS to perform certain tasks as an agent for the recipient/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the recipient for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

B. Criteria.

1. In order to qualify for attendant care, the recipient must demonstrate a need for personal care in activities of daily living, medication or other medical needs, or monitoring health status or physical condition.

2. Consumer-directed respite care may only be offered to recipients who have a primary unpaid caregiver living in the home who requires temporary relief to avoid institutionalization of the recipient, and it is designed to focus on the need of the caregiver for temporary relief.

3. The inclusion of companion care in the CSP is appropriate only when the recipient cannot be left alone at any time due to mental or severe physical incapacitation. This includes recipients who cannot use a phone to call for help due to a physical or neurological disability. Recipients can only receive companion care due to their inability to call for help if PERS is not appropriate for them.

4. Attendant care, companion care, and consumer-directed respite services are available to recipients who would otherwise require the level of care provided in an ICF/MR. Recipients who are eligible for consumer-directed services must have the capability to hire and train their own personal attendants or companions and supervise the attendant's or companion's performance. Recipients with cognitive impairments will not be able to manage their own care. If a recipient is unable to direct his own care, a family caregiver may serve as the employer on behalf of the recipient. Recipients are permitted to share hours for no more than two individuals living in the same home.

5. Responsibilities as employer. The recipient, or if the recipient is unable then a family caregiver, is the employer in this service and is responsible for hiring, training, supervising, and firing personal attendants and companions. Specific duties include checking references of personal attendants/companions, determining that personal attendants/companions meet basic qualifications, training personal attendants/companions, supervising the personal attendant's/companion's performance, and submitting timesheets to the service coordinator and fiscal agent on a consistent and timely basis. The recipient or family caregiver must have an emergency back-up plan in case the personal attendant/companion does not show up for work as expected or terminates employment without prior notice.

C. Service units and service limitations.

1. Consumer-directed respite care services are limited to a maximum of 30 days or 720 hours per calendar year.

2. The amount of companion care time included in the CSP must be no more than is necessary to prevent the physical deterioration or injury to the recipient. In no event may the amount of time relegated solely to companion care on the CSP exceed eight hours per day.

3. Recipients can have consumer-directed respite care and attendant care and in-home residential support services in their service plans but cannot receive these services simultaneously.

4. For attendant care and consumer-directed respite care services, recipients or family caregivers will hire their own personal attendants and manage and supervise the attendants' performances.

The attendant/companion must meet the following requirements:

a. Be 18 years of age or older;

b. Have the required skills to perform consumer-directed services as specified in the recipient's supporting documentation;

c. Possess basic math, reading, and writing skills;

d. Possess a valid Social Security number;

e. Submit to a criminal records check and, if the recipient is a minor, the child protective services registry. The personal attendant/companion will not be compensated for services provided to the recipient if the records check verifies the personal attendant/companion has been convicted of crimes described in §32.1-162.9:1 of the Code of Virginia or if the personal attendant/companion has a complaint confirmed by the DSS child protective services registry.

f. Be willing to attend training at the recipient's or family caregiver's request;

g. Understand and agree to comply with the DMAS IFDDS Waiver requirements;

h. Receive periodic TB screening, CPR training and an annual flu shot; and

i. Be willing to register in a personal attendant registry, which will be maintained by the consumer-directed services facilitator chosen by the recipient or recipient's parent or guardian.

5. Restrictions. Attendants cannot be spouses, parents of minor children, or legally responsible relatives. Payment will not be made for services furnished by other family

members unless there is objective written documentation as to why there are no other providers available to provide the care..

6. Retention, hiring, and substitution of attendants. Upon the recipient's request, the CD services facilitation provider shall provide the recipient or family caregiver with a list of persons on the personal attendant registry who can provide temporary assistance until the attendant returns or the recipient or family caregiver is able to select and hire a new personal attendant. If a recipient or family caregiver is consistently unable to hire and retain the employment of an attendant to provide attendant or consumer-directed respite services, the service coordination provider must contact the support coordinator and DMAS to transfer the recipient, at the recipient's or family caregiver's choice, to a provider that provides Medicaid-funded agency-directed personal care, companion care or respite care services. The CD services facilitation provider will make arrangements with the support coordinator to have the recipient transferred.

D. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, provider must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitation provider and maintain provider status, the CD services facilitation provider must operate from a business office and have sufficient qualified staff who will function as CD services facilitators to perform the needed plans of care development and monitoring, reassessments, service coordination, and support activities as required. It is preferred that the employee of the CD services facilitation provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the individual have two years of satisfactory experience in the human services field working with persons with developmental disabilities. The individual must possess a combination of work experience and relevant education which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills and abilities must be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Types of functional limitations and health problems that are common to different disability types and the aging process as well as strategies to reduce limitations and health problems;

(2) Physical assistance typically required by people with developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications commonly used and required by people with developmental disabilities that reduce the need for human help and improves safety;

(4) Various long-term care program requirements, including nursing home, ICF/MR, and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care services;

(5) IFDDS Waiver requirements, as well as the administrative duties for which the recipient will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;

(7) Interviewing techniques;

(8) The recipient's right to make decisions about, direct the provisions of, and control his attendant care and consumer-directed respite care services, including hiring, training, managing, approving time sheets, and firing an attendant;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with recipients and service providers;

(2) Observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to persons with developmental disabilities; and

(4) Identifying services within the established services system to meet the recipient's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for persons who have visual impairments;

(2) Demonstrate a positive regard for recipients and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, orally and in writing; and

(6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds.

2. If the CD services facilitation staff employed by the CD services facilitation provider is not an RN, the CD services facilitation provider must have RN consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. The RN consultant is to be available as needed to consult with recipients and CD services facilitation providers on issues related to the health needs of the recipient.

3. Initiation of services and service monitoring.

a. Attendant care services. The CD services facilitation provider must make an initial comprehensive home visit to develop the supporting documentation with the recipient or family caregiver and provide management training. After the initial visit, two routine onsite visits must occur in the recipient's home within 60 days of the initiation of care or the initial visit to monitor the supporting documentation. The CD services facilitation provider will continue to monitor the supporting documentation on an as needed basis, not to exceed a maximum of one routine onsite visit every 30 days but no less than the minimum of one routine onsite visit every 90 days per recipient. The initial comprehensive visit is done only once upon the recipient's entry into the service. If a waiver recipient changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.

b. Consumer-directed respite and companion services. The CD services facilitation provider must make an initial comprehensive home visit to develop the supporting documentation with the recipient or family caregiver and will provide management training. After the initial visit, the CD services facilitator will periodically review the utilization of companion services at a minimum of every six months or, for respite services, either every six months or upon the use of 300 respite care hours, whichever comes first. The initial comprehensive visit is done only once upon the recipient's entry into the service. If a waiver recipient changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.

4. CD services facilitator reassessments for consumer-directed services. A reassessment of the recipient's level of care will occur six months after initial entry into the program, and subsequent reevaluations will occur at a minimum of every six months. During visits to the recipient's home, the CD services facilitation provider must observe, evaluate, and

document the adequacy and appropriateness of personal attendant services with regard to the recipient's current functioning and cognitive status, medical, and social needs. The CD services facilitation provider's summary must include, but not necessarily be limited to:

a. Whether attendant care or consumer-directed respite care services continue to be appropriate and medically necessary to prevent institutionalization;

b. Whether the service is adequate to meet the recipient's needs;

c. Any special tasks performed by the attendant/companion and the attendant's/companion's qualifications to perform these tasks;

d. Recipient's satisfaction with the service;

e. Hospitalization or change in medical condition, functioning, or cognitive status;

f. Other services received and their amount; and

g. The presence or absence of the attendant in the home during the CD services facilitator's visit.

5. The CD services facilitation provider must be available to the recipient by telephone.

6. The CD services facilitation provider must submit a criminal record check pertaining to the personal attendant/companion on behalf of the recipient and report findings of the criminal record check to the recipient or the family caregiver and the program's fiscal agent. Personal attendants/companions will not be reimbursed for services provided to the recipient effective with the date the criminal record check confirms a personal attendant has been found to have been convicted of a crime as described in §32.1-162.9:1 of the Code of Virginia or if the personal attendant/companion has a confirmed record on the DSS Child Protective Services Registry. If the recipient is a minor, the personal attendant/companion must also be screened through the DSS child protective services registry.

7. The CD services facilitation provider shall verify bi-weekly timesheets signed by the recipient or the family caregiver and the personal attendant/companion to ensure that the number of CSP approved hours are not exceeded. If discrepancies are identified, the CD services facilitation provider must contact the recipient to resolve discrepancies and must notify the fiscal agent. If a recipient is consistently being identified as having discrepancies in his timesheets, the CD services facilitation provider must contact the support coordinator to resolve the situation. The CD services facilitation provider cannot verify timesheets for personal attendants/companions who have been convicted of crimes

described in §32.1-162.9:1 of the Code of Virginia or who have a confirmed case with the DSS Child Protective Services Registry and must notify the fiscal agent.

8. Personal attendant registry. The CD services facilitation provider must maintain a personal attendant registry.

9. Required documentation in recipients' records. The CD services facilitation provider must maintain all records of each recipient. At a minimum these records must contain:

a. All copies of the CSP, all supporting documentation, and all DMAS-122 forms.

b. All DMAS utilization review forms.

c. CD services facilitation provider's notes contemporaneously recorded and dated during any contacts with the recipient and during visits to the recipient's home.

d. All correspondence to the recipient and to DMAS.

e. Reassessments made during the provision of services.

f. Records of contacts made with family, physicians, DMAS, formal and informal service providers, and all professionals concerning the recipient.

g. All training provided to the personal attendant/companion or attendants/companions on behalf of the recipient or family caregiver.

h. All management training provided to the recipients or family caregivers, including the recipient's or family caregiver's responsibility for the accuracy of the timesheets.

i. All documents signed by the recipient or the recipient's family caregivers that acknowledge the responsibilities of the services.

12VAC30-120-772. Family/caregiver training.

A. Service description. Family or caregiver training is the provision of identified training and education related to disabilities, community integration, family dynamics, stress management, behavior interventions and mental health to a parent, other family members or primary caregiver. For purposes of this service, "family" is defined as the persons who live with or provide care to or support a waiver recipient, and may include a, spouse, children, relatives, a legal guardian, foster family, or in-laws. "Family" does not include

individuals who are employed to care for the recipient. All family training must be included in the recipient's written CSP.

B. Criteria. The need for the training and the content of the training in order to assist family or caregivers with maintaining the recipient at home must be documented in the recipient's CSP. The training must be necessary in order to improve the family or caregiver's ability to give care and support.

C. Service units and service limitations. Services will be billed hourly and must be prior authorized. Recipients may receive up to 80 hours of family/caregiver training per calendar year.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, providers must meet the following qualifications:

1. Family/caregiver training must be provided on an individual basis, in small groups or through seminars and conferences provided by Medicaid-certified family and caregiver training providers.

2. Family/caregiver training must be provided by individuals with expertise who work for an agency with experience in or demonstrated knowledge of the training topic and who work for an agency or organization that has a provider agreement with DMAS to provide these services. Individuals must also have the appropriate licensure or certification as required for the specific professional field associated with the training area. Licensed practical counselors, licensed clinical social workers, and licensed psychologists can enroll as individual practitioners with DMAS to provide family/caregiver training.

12VAC30-120-774. Personal Emergency Response System (PERS).

A. Service description. PERS is a service which electronically monitors recipient safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line.

B. Criteria. PERS can be authorized when there is no one else is in the home who is competent and continuously available to call for help in an emergency. If the recipient's caregiver has a business in the home, such as a day care center, PERS will only be approved if the recipient is evaluated as being dependent in orientation and behavior pattern.

C. Service units and service limitations.

1. A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, and monitoring of the PERS. A unit of service is one-month rental price set by DMAS. The one-time installation of the unit includes installation, account activation, recipient and caregiver instruction, and removal of equipment.

2. PERS services must be capable of being activated by a remote wireless device and be connected to the recipient's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be waterproof, automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and be able to be worn by the recipient.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, providers must also meet the following qualifications:

1. A PERS provider is a certified home health or personal care agency, a durable medical equipment provider, a hospital or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance and service calls), and PERS monitoring.

2. The PERS provider must provide an emergency response center staff with fully trained operators that are capable of receiving signals for help from a recipient's PERS equipment 24 hours a day, 365, or 366 as appropriate, days per year; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS recipient needs emergency help.

3. A PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the services to be performed.

4. The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the recipient's notification of a malfunction of the console unit, activating devices or medication-monitoring unit while the original equipment is being repaired.

5. The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

6. The PERS installation includes local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

7. A PERS provider must maintain all installed PERS equipment in proper working order.

8. A PERS provider must maintain a data record for each PERS recipient at no additional cost to DMAS. The record must document all of the following:

a. Delivery date and installation date of the PERS;

b. Enrollee/caregiver signature verifying receipt of PERS device;

c. Verification by a test that the PERS device is operational, monthly or more frequently as needed;

d. Updated and current recipient responder and contact information, as provided by the recipient or the recipient's care provider; and

e. A case log documenting recipient system utilization and recipient or responder contacts and communications.

9. The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

10. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation ensuring that subsequent signals can be transmitted without requiring manual reset by the recipient.

11. A PERS provider must furnish education, data, and ongoing assistance to DMAS to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the recipient, caregiver, and responders in the use of the PERS service.

12. The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating

without external power during a power failure at the recipient's home for a minimum period of 24 hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the recipient resetting the system in the event it cannot get its signal accepted at the response center.

13. Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from recipients' PERS equipment. The monitoring agency's equipment must include the following:

a. A primary receiver and a back-up receiver, which must be independent and interchangeable;

b. A back-up information retrieval system;

c. A clock printer, which must print out the time and date of the emergency signal, the PERS recipient's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

d. A back-up power supply;

e. A separate telephone service;

f. A toll free number to be used by the PERS equipment in order to contact the primary or back-up response center; and

g. A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

14. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and recordkeeping and reporting procedures.

15. The PERS provider shall document and furnish a written report to the support coordinator each emergency signal that results in action being taken on behalf of the recipient. This excludes test signals or activations made in error.

12VAC30-120-776. Companion care agency-directed model of care.

A. Service description. Companion care is a covered service when its purpose is to supervise or monitor those individuals who require the physical presence of an aide to ensure their safety during times when no other supportive individuals are available.

B. Criteria.

1. The inclusion of companion care in the CSP is appropriate only when the recipient cannot be left alone at any time due to mental or severe physical incapacitation. This includes recipients who cannot use a phone to call for help due to a physical or neurological disability. Recipients can only receive companion care due to their inability to call for help if PERS is not appropriate for them.

2. Recipients who have a current, uncontrolled medical condition which would make them unable to call for help during a rapid deterioration can be approved for companion care if there is documentation that the recipient has had recurring attacks during the two-month period prior to the authorization of companion care. Companion care shall not be covered if required only because the recipient does not have a telephone in the home or because the recipient does not speak English.

3. There must be a clear and present danger to the recipient as a result of being left unsupervised. Companion care cannot be authorized for persons whose only need for companion care is for assistance exiting the home in the event of an emergency.

C. Service units and service limitations.

1. The amount of companion care time included in the CSP must be no more than is necessary to prevent the physical deterioration or injury to the recipient. In no event may the amount of time relegated solely to companion care on the CSP exceed eight hours per day.

2. A companion care aide cannot provide supervision to recipients who are on ventilators or continuous tube feedings or those who require suctioning of their airways.

3. Companion care will be authorized for family members to sleep either during the day or during the night when the recipient cannot be left alone at any time due to the recipient's severe agitation and physically wandering behavior. Companion aide services must be necessary to ensure the recipient's safety if the recipient cannot be left unsupervised due to health and safety concerns.

4. Companion care can be authorized when no one else is in the home who is competent to call for help in an emergency.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, providers must meet the following qualifications:

1. Companion aide qualifications. Agencies must employ individuals to provide companion care who meet the following requirements:

a. Be at least 18 years of age;

b. Possess basic reading, writing, and math skills;

c. Be capable of following a care plan with minimal supervision;

d. Submit to a criminal history record check. The companion will not be compensated for services provided to the recipient if the records check verifies the companion has been convicted of crimes described in §32.1-162.9:1 of the Code of Virginia;

e. Possess a valid Social Security number; and

f. Be capable of aiding in the activities of daily living or instrumental activities of daily living.

2. Companions will be employees of agencies that will contract with DMAS to provide companion services. Agencies will be required to have a companion care supervisor to monitor companion care services. The supervisor must be a certified Home Health Aide, an LPN, or an RN, and must have a current license or certification to practice in the Commonwealth.

3. The provider agency must conduct an initial home visit within the first three days of initiating companion care services to document the efficacy and appropriateness of services and to establish a service plan for the recipient. The agency must provide follow-up home visits to monitor the provision of services every four months or as often as needed. The recipient must be reassessed for services every six months.

12VAC30-120-780. Reevaluation of service need and utilization review.

A. The Consumer Service Plan (CSP).

1. The CSP shall be developed by the support coordinator mutually with other service providers, the recipient, the recipient's parents or legal guardians for minors, consultants, and other interested parties based on relevant, current assessment data. The CSP process

determines the services to be rendered to recipients, the frequency of services, the type of service provider, and a description of the services to be offered. All CSPs developed by the support coordinators are subject to approval by DMAS. DMAS is the single state authority responsible for the supervision of the administration of the community-based care waiver.

2. The support coordinator is responsible for continuous monitoring of the appropriateness of the recipient's supporting documentation and revisions to the CSP as indicated by the changing needs of the recipient. At a minimum, the support coordinator must review the CSP every three months to determine whether service goals and objectives are being met and whether any modifications to the CSP are necessary.

3. The DMAS staff shall review the CSP every 12 months or more frequently as required to assure proper utilization of services. Any modification to the amount or type of services in the CSP must be authorized by DMAS.

B. Review of level of care.

1. DMAS shall complete an annual comprehensive reassessment, in coordination with the recipient, family, and service providers. If warranted, DMAS will coordinate a medical examination and a psychological evaluation for every waiver recipient. The reassessment must include an update of the assessment instrument and any other appropriate assessment data.

2. A medical examination must be completed for adults based on need identified by the provider, recipient, support coordinator, or DMAS staff. Medical examinations for children must be completed according to the recommended frequency and periodicity of the EPSDT program.

3. A psychological evaluation or standardized developmental assessment for children over six years of age must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities. A new psychological evaluation is required whenever the recipient's functioning has undergone significant change and is no longer reflective of the past psychological evaluation.

C. Documentation required.

1. The support coordination agency must maintain the following documentation for review by the DMAS staff for each waiver recipient:

a. All assessment summaries and all CSPs completed for the recipient and maintained for a period of not less than five years;

b. All individual providers' supporting documentation from any provider rendering waiver services to the recipient;

c. All supporting documentation related to any change in the CSP;

d. All related communication with the providers, recipient, consultants, DMHMRSAS, DMAS, DSS, DRS or other related parties; and

e. An ongoing log which documents all contacts made by the support coordinator related to the waiver recipient.

2. The recipient service providers must maintain the following documentation for review by the DMAS staff for each waiver recipient:

a. All supporting documentation developed for that recipient and maintained for a period of not less than five years;

b. An attendance log which documents the date services were rendered and the amount and type of services rendered; and

c. Appropriate progress notes reflecting recipient's status and, as appropriate, progress toward the goals on the supporting documentation.

12VAC30-120-790. Eligibility criteria for emergency access to the waiver.

A. Subject to available funding, individuals must meet at least one of the emergency criteria to be eligible for immediate access to waiver services without consideration to the length of time an individual has been waiting to access services. In the absence of waiver services, the individual would not be able to remain in his home.

B. The criteria are:

1. The primary caregiver has a serious illness, has been hospitalized, or has died;

2. The individual has been determined by the DSS to have been abused or neglected and is in need of immediate waiver services;

3. The individual has behaviors which present risk to personal or public safety; or

4. The individual presents extreme physical, emotional, or financial burden at home and the family or caregiver is unable to continue to provide care.

CERTIFIED:

_____ _____

Date

Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

FORMS

Virginia Uniform Assessment Instrument (UAI) (1994).

Medicaid Funded Long-Term Care Service Authorization Form, DMAS-96 (rev. 8/97).

Service Coordinator Plan of Care, DMAS-97B (rev. 6/97).

Patient Information, DMAS-122 (rev. 12/98).

Questionnaire: Assessing a Recipient's Ability to Independently Manage Personal Attendant Services (2/98).

Questionnaire to Assess an Applicant's Ability to Independently Manage Personal Attendant Services in the CD-PAS Waiver or DD Waiver, DMAS-95 Addendum (eff. 8/00).

DD Waiver Enrollment Request, DMAS-453 (eff. 1/01).

DD Waiver Consumer Service Plan, DMAS-456 (eff. 1/01).

DD Medicaid Waiver--Level of Functioning Survey--Summary Sheet, DMAS-458 (eff. 1/01).

Documentation of Recipient Choice between Institutional Care or Home and Community-Based Services (eff. 8/00).

DOCUMENTS INCORPORATED BY REFERENCE

The Art of Readable Writing, Rudolf Flesch, Ph.D., 1949, revised 1962, Collier Books.