FAMILY CARE MANUAL

NEW YORK STATE
OFFICE OF MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES

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SECTION 10

STATEMENT OF

10.0 OMRDD's Mission Statement

10.0 Background on Family Care

Mission:

The New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) became an independent agency when legislation reorganizing the Department of Mental Hygiene became effective on April 1, 1978.

The State of New York and its local governments have a responsibility for the comprehensively planned provision of services including care, treatment, habilitation, and rehabilitation of their citizens with mental retardation and developmental disabilities, and for the prevention and early detection of mental retardation and developmental disabilities.

The Office of Mental Retardation and Developmental Disabilities' mission is to:

1. Develop a comprehensive, integrated system of services, which has as its primary purposes the promotion, and attainment of independence, inclusion, individuality, and productivity for people with mental retardation and developmental disabilities.

2. Serve the full range of needs of people with mental retardation and developmental disabilities by enhancing community-based services and developing new methods of service delivery.

3. Improve the equity, effectiveness, and efficiency of services for people with mental retardation and developmental disabilities by serving people living in the community as well as those in developmental centers, and by establishing accountability for carrying out the policies of the state with regard to such people; and

4. Develop programs to further the prevention and early detection of mental retardation and developmental disabilities.

OMRDD operates thirteen Developmental Disabilities Services Offices (DDSOs) responsible for providing such programs in one or more counties. These offices seek to provide specifically designed person centered assistance to each individual with developmental disabilities as requested by that person or by his or her family. In partnership with consumers, families, staff, private providers, and local governments, these offices seek to improve the quality of life of individuals and their families through the provision of quality, cost-effective housing, employment, and family support services.

Governing Principles:

The Office of Mental Retardation and Developmental Disabilities (OMRDD) and the many other organizations in New York that provide services and supports to people with developmental disabilities are guided by five principles. The five governing principles are intended to ensure that people with developmental disabilities receive supports and services to successfully live in their community of choice. Supports and services should assist people to live successfully and exercise as much control over their lives as possible.

The five governing principles are:

1. A person with a developmental disability must relate to his or her family, friends, and communities when and how he or she chooses, consistent with the rights and wishes of others.

2. A person with a developmental disability must be as independent as possible and determine the direction of his or her life. Independence means that a person can pursue activities, which she or he decides are important. They can be undertaken with various degrees of reliance on others. Every Family Care provider is expected to encourage and assist each person served and supported to be as independent in as many areas of life as possible. The ability to make decisions and take actions, which improve one's self esteem or self-image must be encouraged by the provider.

3. A person with a developmental disability must have the opportunity to make life choices that do not compromise health and safety, and such choices must be respected and valued. Every person with a developmental disability must have the opportunity to make choices regarding his or her life. To respect and value this means that a Family Care provider will be responsive to the person's choices as well as enable, encourage, and teach individuals to make responsible, appropriate and informed choices. The choices made should not compromise the individual's immediate health and safety or the health and safety of other persons living in the home or community. Choices should be informed and should improve the quality of the person's life.

4. A person with a developmental disability must have the opportunity to communicate his or her feelings, including fears, and have them addressed, and not be subjected to fear of harm or reprisal in connection with the provision of supports and services.

   An individual who is dependent upon others should not have the fear of offending them and suffering reprisals. Family Care providers have a basic and continuous responsibility to minimize the likelihood of harm, especially harm from members

within the household, substitute respite providers, volunteers, and other persons with disabilities.

5. A person with a developmental disability must receive supports and services that are effective and meet his or her needs.

   People with developmental disabilities can expect quality services that address their individual needs. Family Care providers are expected to be diligent in ensuring high quality services and supports that are effective and adapted to meet specific needs and preferences. Effective supports and services from social activities to habilitation should be enabling for people with developmental disabilities. Supports and services should be available to promote and achieve a better quality of life for each person, and the effectiveness of supports and services should be evaluated in terms of measurable and observable outcomes and consumer satisfaction.

The five principles, together with an effort to streamline the OMRDD regulations and the Mental Hygiene Law to make them consistent with the principles and implement cost efficiencies, will help to guide the behavior of organizations and their employees on behalf of people with developmental disabilities.

Background:

The New York State Office of Mental Retardation and Developmental Disabilities (OMRDD's) Family Care Program was developed in August 1931, at Newark State School, now Finger Lakes DDSO. The then Superintendent, Charles Vaux, modeled Newark's program after that of Gheel, Belgium, considered the oldest Family Care Program in the world.

The first Family Care homes opened by Superintendent Vaux, were located in Walworth, New York, a short distance from the state school. In the first eight months of the program, thirty-two children were placed in fourteen homes. A community center was established in the home of one of the "guardians." It provided a space for the medical staff to work from, as well as, recreational space for the residents of the Family Care Program. Two respite beds were also located at the home to be used in the event that the Family Care "mother" needed to leave the home for a day.

With the success of the Newark Program, the State Legislature, in July 1935, allocated funds for the purpose of organizing a Family Care system. The prevailing rate at that time was $4 per week, per person. During the first year 426, men and women were placed in private homes throughout the state, and by that time, Newark's program had grown to 103 "patients."

The early years of the program put an emphasis on custodial care. Placements, for the most part, were made in rural areas that did not allow for a great amount of community participation. Both factors reinforced the philosophy of time-limited interaction between the mentally disabled, and other members of society. The responsibilities of Family Care providers were essentially "to provide basic necessities in a kind and accepting manner." Although the program offered the individual a wholesome environment in a family setting, it did little to develop the individual's personal, and social growth. The program, as originally conceived, was limited to serving those individuals in the mild range of mental retardation, and who did not require additional services. Since 1973, substantial efforts have resulted in the expansion of the population served to include those individuals in all ranges of developmental disabilities.

The State of New York established as two of its major goals, the deinstitutionalization of many of its large facilities and the prevention of the need for institutional setting care for persons with developmental disabilities. To meet this goal, additional community alternatives were developed. However, one of those programs, Family Care, still needed to be enhanced where persons with disabilities lived in a home and received personal care services that provided for continued community living yet were normalizing and conducive to personal growth. In 1978, Family Care providers were included in the personal care

program and receive payments more reflective of services required and provided. The personal care program was a means of providing qualified and capable personal care assistance in conjunction with a supervised community living setting to an individual with a developmental disability who was not yet capable of other independent alternatives. The major goal of the program was the provision of supportive personal care services and community living that were designed to be need specific, as well as, to achieve and maintain the highest level of functioning, self-care and independence for each individual. These services were provided independent of room and board, and payment levels were linked to the intensity and frequency of personal care needs, such as health, interpersonal and communication, activities for daily living, transferring and incidental household functions.

Family Care is a place of residence for individuals of all ages, ethnic, social, financial, and educational backgrounds who are developmentally disabled, as defined, and may exhibit behavior needs, severe medical problems, those who are technologically supported, diagnosed as "failure to thrive," with Fetal Alcohol Syndrome (FAS), or non ambulated. All of these individuals have experienced, and benefited from "family living" in Family Care.

The provision of Family Care services may be long term in that it represents one of the least restrictive, and most independent living arrangements. It provides a first family for some individuals, and an extended family for other individuals. It can provide a permanent home, and contribute toward the total care, and habilitation process for individuals with developmental disabilities or it may afford an individual the opportunity to learn skills necessary for independent living.

In 1986, in an effort to expand the Family Care Program to unserved, and underserved individuals, and provide an opportunity for more individuals with developmental disabilities to experience family living, OMRDD contracted with non-profit agencies to develop Agency Sponsored Family Care (ASFC). The program was envisioned to be available to individuals residing in developmental centers, other residential alternatives in the community, and those living at home whose needs would be better served through family living arrangement.

In 1993, the commissioner developed the Central Office Family Care Advisory Council, which is parallel to the advisory council established at each DDSO. The council is designed to make recommendations to the commissioner regarding planning, operating, administering, and managing of the Family Care Program statewide.

Effective June 1994, the Home and Community Based Services (HCBS) waiver was introduced into the state and voluntary-sponsored Family Care Program. All Family Care

individuals who are eligible for waiver services may choose to participate, and be enrolled in the waiver to receive residential habilitation services in Family Care by the Family Care provider.

Residential Habilitation is a service that provides training, and assistance to acquire, retain, or improve skills needed to perform daily activities in, as well as out of the Family Care home. These activities are based on the needs, and desires of an individual, and can include development of a valued social role, learning about neighbors, and local resources, development of interpersonal skills, experiences in handling unexpected situations, assistance with making informed decisions and choices, help with communicating wants, needs, and preferences, building competencies and creativity, housekeeping, personal care, meal preparation, health care, and social engagements.

Family Care individuals who were eligible and chose to participate for services were enrolled in the waiver, and began receiving a difficulty of care (DOC) payment based on the Individual Service Planning Model (ISPM), a score generated from the Residential Developmental Disabilities Profile 2 (DDP-2). This classified the intensity of the level of care needed by the individual, and placed a classification, and dollar amount on it accordingly.

The needs, choices and preferences of individuals living in Family Care are no different from anyone else's needs, choices or preferences. These individuals need a place to live, a place to learn, and a place to work. They need love, support, guidance, friends, privacy, recreation, good physical, mental, and emotional health. They do not need to be isolated or made to feel that they are different.

Family Care provides these individuals with an opportunity to experience the warm, congenial atmosphere and understanding that comes from living an enriching life with a family.

Many of the individuals living in Family Care are involved in activities outside of the home. These activities may include shopping trips, school activities, and day services, competitive employment, and community recreational activities. Some individuals enjoy retirement from scheduled activities.

SECTION 10.1

RESPONSIBILITIES OF THE SPONSORING AGENCY

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10.1.14 Incidents, Allegations of Abuse and Other Significant Events

10.1.15 Movement or Discharge

10.1.16 Death and Burial

10.1.17 Interstate Compact

OMRDD has the sole legal authority to regulate, and license (issue operating certificates to) Family Care homes in the OMRDD system.

There are many legal precedents establishing that Family Care homes are considered in the same category as private family dwellings for legal purposes, and that Family Care homes are not considered in the same category as boarding homes, rooming houses, or any other business operation. Family Care homes are thus subject to the same local ordinances that apply to all other *private* one and two family dwellings.

Although it is the intention of OMRDD to cooperate with local authorities in the interest of the residents in the communities, the establishment of sound working relationships in the communities will not be confused with issues of law. The DDSO Director is to notify OMRDD's Office of Counsel of any legal conflict and follow-up with a brief written description of the conflict. With the advice and assistance from the Office of Counsel, and Upstate Support or New York City Regional Office, as needed, the DDSO Director makes a determination of how to deal with legal issues, and advises all concerned.

In cooperation with voluntary agencies, each DDSO is to develop Family Care homes to best meet the needs and preferences of individuals within its service area, including vacancies for Family Care individuals in respite situations.

A staff member must serve as a coordinator of the entire Family Care Program at the local DDSO. This staff must be referred to as the Family Care Coordinator and has the functional responsibility of ensuring cooperation among the DDSO's Sponsored Family Care Program, voluntary Agency Sponsored Family Care (ASFC) Programs, the Division of Support Operations, Quality Assurance\Services, and other applicable service organizations with relation to the expansion and sharing of Family Care resources.

The responsibilities of each sponsoring agency for the Family Care Program include:

1. Monitoring written policies and procedures relative to obtaining, reviewing, evaluating and verifying the background of, and information supplied by applicants on *LS 22 Application for Family Care Home Certification* (Policy 10.3.1A).

This information may include but need not be limited to:

i. Statement of history or experience.

ii. Identification of at least three persons who have known the applicant for at least three years, and are not related to the applicant. Please include names, addresses, telephone numbers, where applicable.

iii. Summary or statement of the applicant(s) education.

iv. Information indicating special skills or completed training/courses.

v. Statement of a misdemeanor or a felony conviction.

vi. Check through the State Central Register on applicant(s) and all adults living in the home (Social Service Law Section 424-a (4).

vii. Critical Driver Certification Program.

viii. Finger Printing through Department of Criminal Justice System (DCJS).

ix. Physician's statement attesting to applicant's sound mental and physical health, as well as, identification of all required immunizations.

2. Ensuring provision of adequate staffing levels and appropriate allocation of staff to administer its Family Care Program.

3. Designating a staff member to serve as a coordinator for the Family Care Program of the sponsoring agency. This party is referred to as the Family Care Coordinator in this policy manual.

4. Designating a staff member to serve as the liaison to Agency Sponsored Family Care (ASFC).

5. Ensuring that staff meet on no less than a quarterly basis with staff of the ASFC program.

6. Ensuring that Medicaid Service Coordinators serving Family Care individuals meet the criteria and guidelines outlined in the Home and Community Based Services (HCBS) waiver manual and the Willowbrook Permanent Injunction, where applicable.

7. Providing its Family Care providers with a copy of current OMRDD policies, procedures, and regulations, as well as, the original copy of the Operating Certificate.

8. Ensuring the provision of appropriate training to its Family Care providers and sponsoring agency staff participating in the Family Care Program. For state Family Care providers, the training information must be entered into the Staff Development and Training (DT) System, as soon as possible, to document training.

9. Monitoring its Family Care homes for compliance with OMRDD regulations and policies.

10. Ensuring that all staff making visits to the home treat the provider and his or her family with dignity and respect, and are mindful that this is the provider's home.

11. Ensuring the monitoring of people in the Family Care homes by conducting monthly home visits using *Form 239 Monthly Checklist*, (Family Care Policy 10.4.2A) or more frequently, as may be required.

12. Ensuring that a Family Care home visitation plan has been developed in accordance with OMRDD requirements *Family Care Policy 10.4.3.*

13. Arranging, by the DDSO director or designee, visitations by another staff member knowledgeable of the Family Care Program in those instances where staff assigned are absent and are unable to make a monthly visit to the home.

14. Upon an individual's initial placement in a Family Care home, ensuring that an individual has been provided with:

    a. Adequate clothing appropriate to the individual's needs and preferences in accordance with OMRDD Policy 10.7.18-*Clothing and Personal Supplies for Individuals Upon Moving into Family Care Home.*

    b. Personal hygiene articles and incidental needs.

    c. Adaptive technology, as needed.

    d. Full medical summary to include medical history, medication (previous and current), and other pertinent medical, and/or psychological information to assist the provider in meeting the needs of the individual.

15. Ensuring that individuals residing in Family Care homes are provided with adequate clothing, personal hygiene articles, incidental needs and recreational opportunities.

16. Ensuring that each individual receives a monthly personal allowance, and the Personal Expenditure Plan (PEP) is completed and monitored for each individual living in a Family Care home.

17. Assisting each Family Care provider to receive appropriate respite services, when needed, and where indicated, emergency coverage as may be required.

18. Ensuring that each substitute provider rendering routine or overnight substitute services meet the criteria outlined in *Policy 10.4.4. Approved Substitute Providers.*

19. Ensuring that Revenue Support is notified when an individual is placed on substitute services and when the stay is approved every five consecutive days.

20. Ensuring the prompt notification of Family Care individuals, and providers of change in, or availability of, benefits as a result of legislation or regulations. Notifying the Family Care provider, within sixty days (60), if a change in regulations results in a decrease or increase in funds.

21. Ensuring the formation of a Family Care Advisory Council (Family Care Policy 10.1.3) whose purpose is to advise the agency on matters pertaining to Family Care. Ensuring written documentation and distribution of Council's meetings/minutes noting recommendations requiring action.

22. Collaborating with the Medicaid Service Coordinator, the Family Care Home Liaison, the Family Care provider, the individual (where feasible), the advocate, and with local communities, to provide the individual with programs and services based on the individual's needs, choices and preferences.

23. Ensuring that the Individualized Service Plans (ISPs) is being monitored for quality services, and it facilitates best practices in planning for and delivery of services.

24. Assigning volunteers to individuals residing in Family Care homes, as available, to add a dimension in the scope and quality of Family Care services in accordance with the Individual Service Plan (ISP).

25. Ensuring that the Family Care Home Liaison (FCHL) has developed, reviewed and revised a Residential Habilitation Plan with the Family Care provider for and with each individual, where feasible, living in a Family Care home as specified in the HCBS waiver guidelines.

26. Ensuring that each certified Family Care provider submits at the end of each month a signed *Statement of Affirmation for the Provision of Residential Habilitation Services* (Family Care Policy 10.8.1).

27. Maintaining all pertinent records of each Family Care provider in accordance with OMRDD Policy 10.1.4, and on each individual.

28. Ensuring the provision of the following emergency resources for Family Care providers: (a) 24-hour emergency care assistance. (b) The designation of a 24-hour "Crisis Telephone Number.

29. Ensuring that the Office of Counsel is called prior to a suspension, revocation limitation or temporary suspension of an operating certificate by the DDSO. If it is necessary to effectuate a temporary suspension after business hours or on weekends and/or holidays, Counsel's Office must be called on the first business day thereafter (Family Care Policy 10.5.2).

30. Ensuring that significant events or situations which endanger the well-being of individuals served are promptly reported, investigated, reviewed and corrective actions taken as necessary (Family Care Policy 10.1.14)

31. Ensuring the participation of each individual in appropriate activities, each week, according to his or her ability, and based on his or her choice.

32. Ensuring that a staff person has been designated to assist the Family Care provider in making necessary arrangements and dispositions when an individual dies.

33. Ensuring that the individual has sufficient funds designated for burial, and if such funds are not available, the DDSO director or designee makes available funds for the individual's disposition.

34. Assisting the Family Care provider, and family members, including individuals living in the home, to receive counseling around grief, and loss, if needed.

35. Arranging for an annual recognition activity (ies) for Family Care providers, and guest, at a location convenient to Family Care providers. Where feasible, the sponsoring may recognize respite sitters (Family Care Policy 10.9.2)

36. Ensuring that each sponsoring agency includes Family Care providers on all committees and councils to ensure that awareness of the program is shared with families on the uniqueness of Family Care.

37. Ensuring that there is linkage between the Statewide Family Care Council, the Statewide Family Support Council, the Boards of Visitors and the Self Advocate Association.

38. Ensuring that each sponsoring agency continue to host Family Care recognition events to highlight Family Care, as well as, recognize providers for their excellent work, commitment and dedication.

Rev. August 2004	FAMILY CARE FORMATION FAMILY CARE ADVISORY COUNCIL	Policy 10.1.3

Each DDSO must form a Family Care Advisory Council whose purpose is to advise the DDSO on matters pertaining to Family Care. The DDSO should consider including Agency Sponsored Family Care Providers (ASFC) and staff as part of their council. Each ASFC agency is also required to form a council that includes both providers and staff. This Advisory Council must meet on at least a quarterly basis or more frequently as determined by the membership to conduct regular business. One annual meeting must be scheduled to evaluate the work of the Council and to establish long and short-term goals. A copy of the minutes of each meeting is to be distributed to each council member, Family Care Coordinator or designee and a copy of representative of Upstate Regional Office (URO) Family Care. The chief executive officer of the sponsoring agency or DDSO Director must also receive a copy. Copies must also be made available to providers upon request.

Membership on this Council will consist, at a minimum, of the following Individuals:

1. DDSO Director or Designee to serve as chair.

2. State and Agency Sponsored Family Care Coordinator.

3. One Family Care provider from each county and one (1) alternate served by the sponsoring agency, representing the agency's Family Care providers in that county. For DDSOs with four (4) or fewer counties, it is recommended that at least four (4) providers have representation on the Council and Agency Sponsored Family Care Provider (s), where appropriate.

4. A Family Care Home Liaison.

5. A Member of the Board of Visitors.

6. A Representative of Fire and Safety or a Quality Assurance staff person serving in that capacity.

7. A Registered Nurse.

8. An Individual who lives in Family Care.

9. Other individuals as deemed appropriate by the sponsoring agency to include the deputy director for community services (DDCS) or designee, business officer, quality assurance, staff of representative Family Care from Central Office.

Functions of the Council:

1. To make recommendations to the director/chief executive officer with regards to planning, operating, administering and managing of the Family Care Program.

2. To review and comment on proposed Family Care regulations, policies and procedures to increase the effectiveness of the Family Care Program.

3. To raise issues and/or recommend resolutions for provider-specific concerns.

4. To identify and recommend training needs in specific program areas.

5. To serve as the representative body for providers in that particular DDSO and seek to bring resolution to Family Care issues at the local level.

Length of Term:

Membership on the board should be staggered to provide continuity. It is recommended that each council member serve a three-year term. At the discretion of the director and based on recommendation of staff, a member may be reappointed to serve on the committee.

Selection of Members:

Family Care provider members may be nominated to serve on the council by the Family Care Coordinator, staff of the sponsoring agency or other providers. The nominee must be in good standing in the Family Care Program. The DDSO director\chief executive officer or his or her designee will make the final decision regarding all participants.

FAMILY CARE ADVISORY COUNCIL

NEW MEMBER BALLOT

County _____

I hereby nominate _____ as a candidate

to serve on _____ DDSO Family Care

Advisory Council for the term beginning _____ and
(month, date, year)

concluding _____.
(month, date, year)

Family Care Provider _____ Date _____

NOTE: Ballots must be returned to the following address no later than

_____

_____

_____

_____

_____

Rev. August 2004	FAMILY CARE PROVIDER RECORD	Policy 10.1.4

The sponsoring agency is to maintain a Family Care provider record with current and pertinent information until such time as the Family Care home is no longer in operation. The reason for the closing is to become part of the record.

The provider's record is to be available for review by the Family Care provider, who is to be given the opportunity to submit written comments regarding the contents. Access is to be in conformance with requirements to access such information.

Any Family Care records pertaining to Medicaid reimbursable programs, such as Medicaid Service Coordination or Home and Community Based Services waiver, must be retained for at least six years from the time reimbursement for services was sought, longer if there is an outstanding audit being done.

Generally, the Social Security Administration (SSA) is requiring that all records pertaining to personal allowance be maintained for three years, three months and fifteen days for the personal account ledgers and Personal Expenditure Plan (PEP) from the time they become "inactive". If the record is required for efficient administration of the program then the records may be retained longer than three years. In situations where the provider no longer provides service or has left the program, the sponsoring agency may choose to discard the records after three years, three months and fifteen days. However, for administrative purposes, the sponsoring agency may want to maintain a "core record" of former providers. That is a record of the names, addresses and years of service of these providers.

On a yearly basis, records maintained at the Family Care home, such as outdated Residential Habilitation Plans, Individualized Service Plans, Personal Allowance Ledgers, Personal Expenditure Plans, Medication Administration Forms, Menstrual Records, Clothing Inventories, must be purged from the provider's home file. For those records that must be maintained for audit purposes, the sponsoring agency must ensure that these files are accessible for the specified period of time.

It is recommended that each Family Care provider's record be organized in a 3-ring binder with indexes listing current information.

The contents of the Family Care provider record are to include, but not be limited to:

1. Completed certification and recertification information to include:

    a. Home study (ies) and a copy of the initial and current operating certificate.

b. The *LS 22 Application for Family Care Home Certification* or Form 240 *Reaffirmation for Recertification.*

c. A copy of the signed Statement of Prohibition of Abuse and Neglect.

d. A statement of required testing or immunization.

e. A copy of the most recent Fire and Safety Inspection, Form 236 Survey for One and Two Family Dwellings or Form 236A Survey for Multiple Dwellings.

f. Three letters of recommendation from persons not related to the Family Care provider.

g. A copy of the State Central Register Clearance Form and any correspondence relating to the submission.

h. A copy of the Critical Driver's Report.

i. Check through the Department of Criminal Justice System (DCJS).

j. A copy of the Off-Duty Conduct Form, if applicable.

2. Correspondence regarding the operation of the Family Care home.

3. Any recognition, awards or commendations.

4. Records of serious reportable incidents and/or allegations of abuse which occurred in the Family Care home or while an individual was under the care and supervision of the Family Care provider.

5. Records of any adverse actions taken regarding the provider and\or the operating certificate.

6. Documentation of complaints that have been substantiated, i.e., a letter, an incident report(s), etc.

7. Documentation of substitute service use and information regarding approved substitute provider(s), i.e., a copy of substitute provider's application, with documentation of ten hours of initial training and five hours of training for reapproval (Reference Policy 10.4.4).

8. Other pertinent historical information such as certification dates, placements, home evaluations, etc.

9. Fire evacuation plan and record of fire evacuations.

10. Documentation of training or other certificates (list of training courses, workshops or seminars) attended during the year. For state Family Care providers, training must be documented in Staff Development and Training (DT) system.

11. Documentation of home visits and assessments using Form 239 Monthly Checklist and Form 238 Family Care Home Evaluation and Survey.

12. Statement of the Affirmation of the Provision of Residential Habilitation Services for each month services are delivered.

13. A copy of the Medicaid Service Coordinator Observation Report (SCOR).

14. A copy of the Co-Opcert Form e-mailed to Information Support Services.

15. Verification of pet immunization.

16. Verification of annual furnace and air-conditioning cleaning.

Individuals living in Family Care may benefit from carrying on their person some means of official identification. The Medicaid Service Coordinator, with the assistance of the Family Care provider is to encourage individuals to obtain an appropriate form of identification.

One type of identification may be obtained from the Department of Motor Vehicles (DMV) or other government agencies in the form of a non-driver photo I.D. There may be a processing fee. The DDSO can provide information as to the process to be followed.

Some individuals may wish to have a last will and testament prepared for them. Exploring this possibility is the responsibility of the sponsoring agency, and is to be done at such time as may seem appropriate, and certainly if an individual expresses the desire to dispose of his or her belongings in a particular way.

The procedure begins with the agency contacting an attorney who specializes in creating wills. Common sense should also be used by the agency and the attorney to ascertain that the individual comprehends what he or she is doing in creating a will. Following this, the attorney will assist the individual to understand the essentials of:

1. What a will is.

2. That he or she is in the process of making a will.

3. The extent of his or her property or assets.

4. To whom he or she is leaving the property or assets; and

5. The role of the agency, so a conflict of interest is not perceived.

June 1998	FAMILY CARE MEDICAL EXAMINATION PRIOR TO ADMISSION	Policy 10.1.7

Within 30 days prior to an individual's moving to a Family Care home, each individual is to receive a medical examination. Pre-admission or laboratory tests may be accepted if they have been performed and documented within 90 days prior to admission. This examination will form the basis for the design of a health care service plan, as part of the individual's plan of care. As warranted, there should be an assessment of the individual's health, reviewing all systems, with appropriate follow-up based upon the age and condition of the individual.

An exception to this will be made for individuals who are currently being served in the OMRDD system who have had a physical examination and laboratory work within the past year. The individual's health care records must be made available and sent to the new health care provider if there has been a change. If the individual's health care records are not available, a physical examination and laboratory work is required. If for any reason, the team feels that the individual's health care status has changed from the time of the last examination, a new physical examination will be required.

A physical examination should be documented and include, but not be limited to:

1. A complete review of medical history to include a review of medications.

2. A complete physical examination to include:

    a. a detailed examination of all systems

    b. height, weight, vital signs

    c. gross assessment of vision and hearing

    d. breast examination (including women and men). (GYN for women)

    e. rectal examination

    f. assessment of need for physical therapy

g. testing for tuberculosis (TB) with the purified protein derivative (PPD) Mantoux skin test

h. Hepatitis status, an immunization record, assessment for physical therapy and podiatry.

3. Detailed review of seizure record and anticonvulsant medication of persons with epilepsy.

4. Laboratory work as follows:

a. complete blood count and differential

b. urinalysis

c. a chemistry profile to include at least the following:

Albumin	Phosphorus	Glucose	Uric Acid
Alkaline Phosphatase	SGOT	BUN	SGPT
Calcium	Total Bilirubin	Electrolytes	
Creatinine	Total Protein	Complete Lipid Panels	

An individual may move to a Family Care home without legal status or being on conditional release status. Individuals who are retained under an order pursuant to the Criminal Procedure Law cannot be placed in the Family Care Program unless prior permission is obtained from the commissioner.

The individual may move into Family Care when:

1. The individual has been diagnosed as having a developmental disability which:

   a). is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, or autism; or

   b). is attributable to any other condition of an individual found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of individuals with mental retardation or requires treatment and services similar to those required for such individuals; or

   c). is attributable to dyslexia resulting from a disability described in paragraph (1) or (2) of this subdivision; and

   d). originates before such individuals attain age twenty-two(22); and

   e). has continued or can be expected to continue indefinitely; and

   f). constitutes a substantial disability to the ability to function normally in society.

2. The individual's needs and preferences can be met by the Family Care Program.

3. Medicaid Service Coordinator or another staff identified by the sponsoring agency is to:

   a). Complete Form 725 to register the individual into the Family Care Program.

   b). Complete the *Application for Admission to Family Care* - Form FCA- 01.

c). Complete Section III (a), if the individual is over age 18 and capable. If the individual is 18 and over and not capable or under age 18, Section III (b) should be completed by the parent or guardian.

d). Provide the parent or legal representative with a copy of the *Application for Admission to Family Care* - Form FCA- 01, ensuring that the form is complete and accurate.

e). Provide the individual, parent or guardian with a copy of Form FCA - 02 *Notice of Rights (14 NYCRR Part 633.4),* ensuring that the parties understand these rights.

f). Obtain signature of the individual, parent or guardian on Form FCA - 03 *Acknowledgment of Rights*, ensuring that the form is complete and legible.

g). Place the original copy in the individual's file, and disseminate the other copies to appropriate parties.

OMR-FCA-01-98 OMRDD APPLICATION FOR ADMISSION TO THE FAMILY CARE PROGRAM

I. Identifying Data For Admission To The Family Care Program
(Type or print clearly)

Name (Last) (First) (Middle) M/F

Address (City) County State Zip Code

Place of Birth (City) County State Zip Code

Date of Birth: _____ U.S. Citizen: Yes ____ No ____ How Long in US?

Medicare Claim No: _____ Medicaid No: _____

Social Security No: _____ Telephone No:

LIVING RELATIVES*	RELATIONSHIP	AGE	ADDRESS

*** List primary contact, if no relatives.**

Prior Receipt Of Services For Developmental Disability

NAME OF AGENCY	ADDRESS	DATE OF ADMISSION

II. Reason(s) For Requesting Admission To The Family Care Program.

_____

_____

_____

III. (a). I, _____, hereby apply for admission to

_____Sponsoring Agency Family Care Program.

Signature (Age 18 or Over) _____ Date _____

(b). For individuals who are 18 and over and not capable of making application to the Family Care Program or under the age of 18, the parent, advocate or correspondent should complete this section.

I, _____ behalf of my son, _____

or daughter _____ or_____

make application for (his) or (her) admission to _____

Sponsoring Agency Family Care Program.

_____ _____

signature: Parent/Advocate or Correspondent (Circle One) Date

Distribution: Original - Clinical Records or TABS Coordinator
Canary - Individual's File
Pink – Individual/Parent/Advocate or Correspondent
Green - Revenue Support Field Office
OMR-Form 01

OMR-FCA-02/00

OMRDD
DIRECT FAMILY CARE ADMISSION
NOTICE OF RIGHTS (14 NYCRR PART 633.4)

Each individual, and his or her parent(s), advocate(s) or correspondent(s) prior to or upon admission to the Sponsoring Agency's Family Care Program and subsequent to any changes that may occur thereafter, will be notified of the individual's rights and the Sponsoring Agency's rules governing the individual's conduct, unless the individual is a capable adult who objects to such notification to a parent or correspondent. All attempts will be made to convey such information in the primary language of the individual, parent, advocate or correspondent.

Each individual capable of doing so will acknowledge, in writing, the receipt of such information and any amendments to it. If the individual being admitted to the Family Care Program is not capable of understanding his or her rights and/or the Sponsoring Agency's program rules and procedures, such information will be supplied to the individual's parent(s), advocate(s), or correspondent(s).

OMR-FCA-03/00

OMRDD
14 NYCRR PART 633.4
ACKNOWLEDGMENT OF RIGHTS NOTIFICATION FORM

The following have received 14 NYCRR Part 633.4 on the date indicated.

Date	Print Name	Signature of Person
Date	Print Name: Witness	Signature of Witness
Date	Print Name: Parent, Advocate Correspondent (Circle One)	Signature of Parent, Advocate, Correspondent (Circle One)

Within 30 days of an individual moving to a Family Care home, the sponsoring agency may, in situations where they deem appropriate, initiate contact with the individual's natural parents, adoptive parents or guardian. A parent search is not to be conducted for the natural parents of children judicially surrendered or legally adopted in accordance with court procedures.

The sponsoring agency is to conduct a search to locate the parent or guardian, if they cannot be located immediately. Parent search procedures are to be conducted in a manner that protects confidentiality. To confirm that the search for the parent or guardian is completed with due diligence, the sponsoring agency staff is to, as part of their efforts, interview the Family Care provider, day program and other appropriate persons or programs to obtain information regarding visitors to a person for possible information as to the location of parents or guardian.

There is to be documentation in the individual's record as to the results of the search procedures and as to whether the parent or guardian will actively participate as the correspondent or advocate. A capable adult can decline a search for his or her parent(s).

Name of Sponsoring Agency _____ Address _____

Zip Code _____ Telephone # _____ Fax # _____

Name _____ DOB _____ TABS ID _____

Address _____ Zip Code _____ Telephone No.

Date Initiated _____ Date Completed

Final Determination: Check One_____ Parent(s) Located _____ Parent(s) was not Located

Current Information for the Individual:

Name _____

Address _____ City _____

State _____ Zip Code _____ Telephone _____

Steps Undertaken	Completed Date	Initial	Comments and Findings
1. Examination of Clinical record for parent a. Last known address and telephone number b. Last contact with person (enter date)			
2. Telephone check with local OMRDD Revenue Support, Social Services, Social Security Office, Department of Mot Vehicle, etc.			
3. Letters (certified and regular mail) to last known address of parent (list address below).			

Steps Undertaken	Completed Date	Initial	Comments and Findings
4. Results of parental visits to last known address (If applicable):			
5. Telephone Check (s) a. Telephone directory b. Telephone company c. Telephone check with last place of employment, list place of employment.			
6. Discussion with Family Care provider, day program staff or employer, and other appropriate staff.			

Steps Undertaken	Completed Date	Initial	Comments and Findings
7. Telephone and/or written contact with other interested parties or agencies noted in the record: List these below a. Contact: b. Contact Method:			

Steps Undertaken	Completed Date	Initial	Comments and Findings
8. Contact with other possible resources as appropriate: a. Contact Method: Armed Services b. Contact Method: New York State Department of Health c. Contact Method: New York State Department of Motor Vehicles d. Contact Method: Social Security Administration e. Other (Specify)			

(Optional) OMR-FC/1011 Rev. 12/00

Name and Title of Staff Completing Search Procedures

Date

FAMILY CARE
ADVOCATE\CORRESPONDENT
REPRESENTATION FOR INDIVIDUALS
LIVING IN FAMILY CARE

Rev. August 2004 **Policy 10.1.10**

In consultation with a capable adult, provision is to be made for all individuals who are living in a Family Care home to be represented by a correspondent or an advocate. Each person has the right to decline having an advocate/correspondent. In the first instance, a correspondent or advocate would be the parent or guardian listed in the Individualized Service Plan. If parents are deceased or their whereabouts cannot, with due diligence, be ascertained, or they have failed to designate an appropriate representative, and there is no guardian, then the correspondent or advocate may be the relative or other interested parties if any, in closest relationship with the individual who has, at least once within the previous year, manifested interest in the individual by communication with the sponsoring agency regarding the individual or by visiting the individual. If none of the above can be located, or if such party or parties refuse to participate in the service planning process for the individual, the sponsoring agency's chief executive officer is to designate a substitute to act as the individual's correspondent or advocate, unless the individual is a Member of the Willowbrook Class, an advocate cannot be a member of the family Care provider's family. For Members of the Willowbrook Class, regardless of present living arrangement, the correspondent or advocate is a member of the Consumer Advisory Board established by the Willowbrook Consent Judgment.

For individuals of school-age for whom it has been necessary to designate a correspondent or advocate other than the individual's parent or guardian, the individual's surrogate parent (see Policy: 10.1.12, *Surrogate Parents for School Age Individuals in Family Care Homes*) may be asked to participate as the individual's correspondent or advocate. It is the responsibility of the residential sponsoring agency's chief executive officer to develop specific policies and procedures for contacting the surrogate parent regarding this party's participation as the individual's correspondent. Only the surrogate parent\correspondent or advocate needs to be identified to participate in both the educational and service planning processes for an individual of school age. It is not necessary to identify two separate individuals, one to function as an appointed surrogate parent and another to function as a designated correspondent or advocate for the same individual.

The correspondent or advocate receives notification of significant events in the life of the person and represents the individual on, but not limited to, the following occasions:

1. During the preparation, implementation and review of the individualized plan of care.

2. At scheduled formal meetings when the individual is discussed by current providers of service or those who will be providing services to the individual within six months of the meeting.

3. During the discussion and planning for any movement of an individual.

The representation of a capable adult by a correspondent or advocate is subject to an objection by that adult. The assessment of capability for the purpose of this policy is made by the team. If the individual is a capable adult and specifically requests the exclusion of a correspondent or advocate as his or her representative in the individual's service planning process, the sponsoring agency staff is to document this request, have it countersigned by the capable adult and place it in the individual's record. Because the individual's parent, guardian or committee is considered to be the individual's correspondent or advocate in the first instance, he or she is to be contacted immediately upon the admission of the individual to the Family Care home to determine if that individual will assume the role of correspondent or advocate.

If the parent or guardian cannot immediately be located based on the information in the individual's record, then the sponsoring agency is to promptly initiate search procedures (see Policy: 10.1.9, *Parent Search Procedures*).

If the individual does not have a living parent or guardian, or, the parent or guardian is unable or does not want to act as correspondent or advocate, then a correspondent or advocate is to be designated by the sponsoring agency chief executive officer (see Policy: 10.1.13, *Designation\Verification of an Advocate Other Than the Individual's Parent or Guardian).*

If a designated correspondent or advocate is temporarily unable to function in that capacity due to personal reasons or the permanent designation of an individual's correspondent or advocate has not been made within 30 days of admission (due to continuing search procedures), a temporary correspondent or advocate is to be designated by the sponsoring agency's chief executive officer. The sponsoring agency staff is to review and document in the individual's record, on a monthly basis, the participation of a temporary correspondent until the permanent correspondent or advocate assumes his or her role or has been designated. There should be an annual review and verification of every individual's designated correspondent.

Whenever a sponsoring agency receives written notification that a designated correspondent is unable or no longer wishes to act in that capacity, the sponsoring agency is to provide the designation of another correspondent or advocate within 30 days of this notification (see Policy: 10.1.11, *Designation\Verification of Parent or Guardian as Correspondent or Advocate, and* 10.1.13 *Designation\Verification of an Advocate Other than Parent or* Guardian).

The correspondent or advocate will, *subject to an objection by a capable adult:*

1. Participate in the development of the Individualized Service Plan.

2. Receive invitations to participate in team conferences related to the individual's annual reviews of the Individualized Service Plan.

3. Be informed periodically of the individual's educational, vocational and living skills progress, and medical condition. For Members of the Willowbrook Class periodically means at least quarterly.

4. Participate in the discussion, planning and, where appropriate, approval of any relocation of the individual.

5. Receive all notifications related to any individual's relocation, hospitalization, involvement in a reportable incident, or an allegation of abuse.

6. Receive a summary of the periodic reviews of the Individualized Service Plan.

7. Participate in the discussion and planning of an individual's participation in a program involving aversive conditioning or research. The advocate cannot, however, give informed consent.

8. Follow current procedures for handling objections if the correspondent or advocate believes the Individualized Service Plan or proposed movement to another residential setting is not in the individual's best interest.

June 1998	FAMILY CARE DESIGNATION/VERIFICATION OF PARENT, GUARDIAN OR AN ADVOCATE	Policy 10.1.11

Every sponsoring agency is to ensure that all individuals living in its homes have an advocate unless the individual is a capable adult and declines to having an advocate. Upon an individual's moving to, the sponsoring agency is to ensure that the individual has an identified advocate listed in his or her record.

If there is no advocate identified, then an advocate is to be designated within the first 30 days of admission. The parent or guardian is considered to be the advocate in the first instance, and is to be contacted immediately upon moving of the individual to determine if he or she wishes to be the individual's advocate. If the parent or guardian agrees to actively participate in the program planning process for the individual and to assist the individual in obtaining necessary services, then this shall be noted in the individual's record, and that party is to be designated as the advocate. If the parent or guardian cannot be located based on the information in the individualized service plan, then the sponsoring agency is to immediately initiate search procedures (see Policy: 10.1.9, *Parent Search Procedures).*

If the individual does not have a living parent or guardian, or the parent or guardian does not want to act as an advocate, then an advocate is to be designated by the sponsoring agency (see Policy: 10.1.13, *Designation/Verification of an Advocate Other than the Parent, or Guardian).*

SAMPLE LETTER
MUST BE ON SPONSORING AGENCY LETTERHEAD

Dear

Thank you for your willingness to participate as an advocate for (Name) in order to assist (Name) in obtaining services and in planning (Name) program.

As advocate, your responsibilities include, but are not limited to:

1. Participating in the development of (Name) Individualized Service Plan (ISP).

2. Attending and participating at (Name) quarterly and annual review meetings.

3. Participating in discussing, planning, and, where appropriate, approving of any proposed moving of (Name).

4. Attending and participating at other scheduled meetings concerning (Name)

5. Using current procedures for handling objections, if you feel that (Name) Individualized Service Plan (ISP) and/or proposed living arrangement is not in (Name) best interest.

Your concern, interest and cooperation in assisting (Name) in achieving the maximum development in the least restrictive environment possible and in helping to enhance the quality of life for (Name) is greatly appreciated.

If you have any questions concerning your participation as (Name) advocate, please feel free to contact me at.

Sincerely,

SAMPLE LETTER
MUST BE ON SPONSORING AGENCY LETTER HEAD

Dear

As you are aware, it is the policy of the Office of Mental Retardation and Developmental Disabilities (OMRDD) to ensure that each individual receiving services in a home has an advocate to assist (Name) in obtaining services and to participate in developing the Individualized Service Plan (ISP) with that individual, unless that individual is an adult and does not wish to have an advocate.

Since you have expressed the desire not to participate as the advocate for (Name) at this time, we are required to designate an appropriate person to act in this capacity. If you have any questions or in the event that you change your mind, please contact (The Family Care Unit) at the above address.

Sincerely,

Family Care Staff

Rev. October 2000	FAMILY CARE SURROGATE PARENTS FOR SCHOOL AGE CHILDREN	Policy 10.1.12

In accordance with Section 200.5(e) of 8 New York Code Rules Regulations, a surrogate parent is to be appointed by the Board of Education, in the school district where the Family Care home is located, for each child with disabilities if the parents of the child are deceased, unavailable, or their whereabouts cannot with due diligence be ascertained and there is no guardian. In the case of a school-age adult (18-21), a surrogate parent may be appointed by the Board of Education subject to the objection of an individual who is capable of objecting and does so.

It is the responsibility of the administrator of the sponsoring agency's education program (or a designated staff person) to recommend to the Board of Education individuals who are willing to serve as surrogate parents for children who live in Family Care homes and are in need of a surrogate parent.

Prior to moving a child to a Family Care home, the child's Medicaid Service Coordinator is to inform the child's parent of his or her rights with regard to the child's educational placement. In addition, the child's Medicaid Service Coordinator is to determine whether or not the parent will be available to assist in the educational planning process. This contact is to occur even if a surrogate parent has already been appointed for the child. If it is necessary to appoint a surrogate parent for a child who resides in a Family Care home, the Medicaid Service Coordinator is to inform the administrator of the sponsoring agency's education program (or designated staff) that this action will be necessary. The Medicaid Service Coordinator is to recommend at least one individual to serve as surrogate parent. This recommendation is to include the Family Care provider, or the party who acted as surrogate parent for the child while the child resided in the developmental center (if applicable), or the child's correspondent, if other than the child's parent. If it is not necessary to appoint a surrogate parent, the Medicaid Service Coordinator is to notify the administrator of the sponsoring agency's education program (or a designated staff person) of the name and address of the child's parents.

If it is necessary to appoint a surrogate parent for the child, the administrator of the sponsoring agency's education program (or a designated staff person) is to file a request for assignment of a surrogate parent with the chairperson of the Committee on Special Education for the School District in which the Family Care home is located. This request is to include a statement of the reason it is necessary to appoint a surrogate parent and a recommendation as to who should be appointed. The chairperson of the School District Committee on Special Education should follow the procedures described in Section 200.5(e)(2) of 8 NYCRR for the assignment of a surrogate parent. The administrator of the sponsoring agency's education program (or designated staff) is to take appropriate action to verify that a surrogate parent has been appointed and is to inform the Medicaid Service Coordinator who notifies the child's parent of the name and address of the surrogate parent appointed by the Committee on Special Education, and documents this information in the child's record.

June 1998	FAMILY CARE DESIGNATION/VERIFICATION OF AN ADVOCATE OTHER THAN THE INDIVIDUAL'S PARENT OR GUARDIAN	Policy 10.1.13

Every effort is to be made to encourage the participation of an advocate in the development, implementation and review of the Individualized Service Plan (ISP). This effort is to include such considerations as providing the advocate with information on the role and responsibilities of an advocate, meeting the individual he or she represents and orienting the advocate to appropriate concerns related to the individual. The parent or guardian is considered to be the individual's advocate in the first instance. If the parent or guardian listed in the individual's record cannot or will not participate as an active advocate, the school district where the Family Care home is located will designate another party to act as the individual's advocate.

When it has been determined that the parent or guardian is not going to participate as the advocate, the school district will determine the names of relatives and/or other parties who may be willing to actively participate as the individual's advocate due to the interest they have shown in the individual's welfare.

For those of school age for whom a surrogate parent has been appointed, the surrogate parent may be asked to participate as the individual's advocate. If the interested party agrees to assume the responsibility as the advocate, then this is to be noted in the individual's record and the individual may be designated as the advocate by the sponsoring agency's chief executive officer (or designee).

If none of the potential advocates contacted will assume responsibility as the individual's advocate, then the sponsoring agency is to ensure the designation of a member of an appropriate advisory group or other organization that offers guardianship or advocacy services, to act as advocate for the individual.

The willingness of each advocate to actively participate in the ISP process for an individual is to be reviewed and verified at least annually. The annual review is to include information concerning the continuing efforts made to identify an advocate for those individuals on non-advocate status. This review and verification are to be documented in the individual's record.

SAMPLE LETTER
MUST BE ON SPONSORING AGENCY LETTERHEAD

Dear

Thank you for your willingness to participate as an advocate for ___(Name)___ in order to assist (Name) in obtaining services and in planning (Name) program.

As the advocate, your responsibilities include, but are not limited to:

1. Participating in the development of (_____Name_____) Individualized Service Plan (ISP).

2. Attending and participating at (_____Name_____) quarterly and annual review meetings.

3. Participating in the discussing, planning, and, where appropriate, approving of any proposed moving of (____Name____).

4. Attending and participating at other scheduled meetings concerning (____Name___).

5. Using current procedures for handling objections, if you feel that (____Name____) Individualized Service Plan ISP) and/or proposed living arrangement is not in (____Name____) best interest.

Your concern, interest and cooperation in assisting (_____Name_____) in achieving the maximum development in the least restrictive environment possible and in helping to enhance the quality of life for (____Name____) is greatly appreciated.

If you have any questions concerning your participation as (___Name___) advocate, please feel free to contact me at _____.

Sincerely,

Significant events or situations which endanger the well being of individuals served must be promptly reported, investigated, reviewed and corrective actions taken as necessary. Individuals served under OMRDDs auspices have a right to humane treatment and to be free from verbal, physical or sexual abuse. Excuses or justification for any type of individual physical and/or psychological abuse, neglect or individual mistreatment in any form, will not be tolerated.

Sponsoring Agency Responsibility:

Each sponsoring agency with oversight responsibilities for Family Care must develop incident and\or abuse policies and procedures that are in conformance with 14 NYCRR Part 624 to provide for the:

1. Reporting, recording, investigating, reviewing and monitoring certain events or situations to enhance quality of care provided to individuals, to protect them from harm, and to confirm that such individuals are free from psychological and physical abuse.

2. Identifying reporting responsibilities of Family Care providers.

3. Consistently, with the demands of the situation, provide counseling to the individual and to other individuals living in the home, as appropriate.

4. Developing and implementing a plan to prevent a recurrence and/or to remediate the situation.

The sponsoring agency must follow-up and immediately investigate, within 24 hours for serious reportable incidents or allegations of abuse. The sponsoring agency must, within 48 hours for reportable incidents, follow-up and investigate all reportable incidents. The investigation must cause as little disruption as possible to the daily routine of the individual(s) being served, yet provide for ensuring of health, safety, and confidentiality.

When it appears that a crime has been committed, the crime must be reported to the district attorney or other law enforcement officials having jurisdiction, and the commissioner of OMRDD, as soon as possible but at least within three (3) working days.

In addition to actions previously discussed, if a serious or reportable incident of abuse is alleged, the discovering agency must:

1. Make a written record of the report on Form OMR 147 Allegation of Abuse.

2. Evaluate the information to determine an appropriate course of action to be taken immediately and/or subsequently.

3. Investigate (the voluntary sponsoring agency of a Family Care home does this in conjunction with the DDSO) and follow-up to the extent possible, and use available community resources where necessary to include law enforcement authorities, the Office of Children and Family Services child and adult protective services.

4. Keep the DDSO informed on at least a monthly basis of the progress or results of the investigation of serious reportable incidents or allegations of abuse.

5. Take photographs of the victim.

OMRDD Responsibility:

Consistent with the demands of the situation, one or more of the following actions may be considered and implemented while an allegation of abuse is being investigated based on 14 NYCRR Part 624 Reportable Incidents and Abuse.

1. Temporary suspension of the provider's Operating Certificate. This can include removal of one or more of the individual's from the Family Care home. The Office of Counsel must be contacted for the legal requirements relating to the specific situation.

2. Increasing the degree of supervision of the person suspected of abuse.

3. Providing appropriate training to assure that a recurrence does not occur.

4. Increasing supervision and providing additional support to restore a secure environment.

5. Removing or relocating the individual(s) consistent with his or her needs, preference or choice, at the request of the family, or at the request of the Family Care provider.

When an allegation is disconfirmed, immediate and appropriate action must be taken to reinstate the Operating Certificate if it had been temporarily suspended and to drop the charges.

Responsibility of the Family Care Provider:

A Family Care provider is responsible for assuring a supportive and caring environment exists for each individual who lives in the home.

In the event a provider witness or finds an allegation of abuse, the provider must act immediately to assure measures are implemented to protect the individual. The incident must be reported to the Family Care Home Liaison.

The Acronym **PERIL** (provided by Taconic DDSO Office of Staff Development and Training), may help providers to remember what steps must be taken if an incident is witnessed.

"P" - PROTECT IMMEDIATELY FROM FURTHER HARM
"E" - EXAMINE (BY NURSE OR PHYSICIAN)
"R" - REPORT TO FAMILY CARE HOME LIAISON, ADMINISTRATOR ON CALL AND/OR NURSE
"I" - INCIDENT REPORT TO BE COMPLETED
"L" - LOOK FOR WAYS TO PREVENT RECURRENCE

1. Reports immediately, but no later than twenty-four (24) hours, all incidents of possible abuse and/ or neglect including injuries to the individual, to the Family Care Home Liaison or other designated staff persons.

2. Reports all other incidents to the Family Care Home Liaison no later than forty-eight (48) hours.

3. Provides, to the best of his or her ability, written information concerning the alleged abuse, neglect and\or incident.

4. Requests assistance, in writing, from the Family Care Home Liaison and/or other DDSO staff to prevent the incident, abuse and/or neglect from recurring.

5. Cooperates, to the fullest extent possible, with staff conducting the investigation.

REPORTABLE INCIDENTS

1. **Injury**

   Any suspected or confirmed harm, hurt, or damage to an individual receiving services, caused by an act of that individual or another, whether or not by accident, and whether or not the cause can be identified which results in an individual requiring medical or dental treatment, by a physician, dentist, physicians' assistant, a nurse practitioner, and treatment is more than first aid. Illness in and of itself should not be reported as an "injury". Injuries include: self-abuse, accident, assault, fight, unknown cause, individual and/ or individual abuse, choking, improper substance ingestion, behavioral intervention, X-rays due to injuries or unknown cause (not medical).

2.

SERIOUS REPORTABLE INCIDENTS

1. **Injury**

   Any injury that results in the admission of the individual to a hospital for treatment or observation because of the injury. (Note: If the injury is suspected to have been caused by abuse, the abuse must be reported in accordance with 624.4(c))

2. **Missing Person or Leave Without Consent**

   The unexpected or unauthorized absence of an individual after formal search procedures (FSP) have been initiated by the sponsoring agency.

   a. Formal search procedures (FSP) must be initiated if an individual's where-abouts are unknown for four hours. AN incident report is to be initiated at this point.

b. Reasoned judgment, taking into account, the individual's habits, deficits, capabilities, health problems, must determine when formal search procedures need to be implemented.

c. It is mandated that formal search procedures be initiated immediately upon discovery of the absence of an individual whose absence constitutes a recognized danger to the possible well being of that individual or others.

REPORTABLE INCIDENTS

3. **Death**

All loss of life, regardless of cause.

4.

SERIOUS REPORTABLE INCIDENTS

3. **Death**

Death when due to circumstances unrelated to the natural course of illness or disease; an apparent homicide or suicide; or an unexplained or accidental death.

4. **Restraints**

The unauthorized use of any device which prevents the free movement of the individual's arms or legs; or totally immobilizes the individual.

Any medication as ordered by physician which renders an individual on unable to satisfactorily participate in programming, leisure or other activities.

5. **Medication Error**

- Wrong Individual
- Wrong Medication
- Wrong Dose
- Wrong Route
- Wrong Time or Failure to Administer

5. **Medication Error**

Only when the error results in the admission of the individual to a hospital for treatment or observation

REPORTABLE INCIDENTS

6. **Possible Criminal Acts**

See Serious Reportable

7. **Sensitive Situations**

Those individual-related situations not described above, which may be of a delicate nature to the sponsoring agency, and which are reported to the administration to apprise their awareness of the circumstance.

SERIOUS REPORTABLE INCIDENTS

6. **Possible Criminal Acts**

Actions by individuals receiving services, which are or appear to be a crime under New York State or Federal Law.

7. **Sensitive Situations**

Those sensitive situations which, in the judgment of the director, need to be brought to the attention of OMRDD, through the DDSO, as expeditiously as possible.

ABUSE

The maltreatment or mishandling of an individual which would endanger the physical or emotional well-being of an individual through the action or inaction on the part of anyone, including Family Care providers, an employee, volunteer, consultant, contractor, visitor, other people, whether or not the individual is, or appears to be injured or harmed.

The failure to exercise one's duty to intercede on behalf of an individual receiving services also constitutes abuse.

While an individual receiving services may have allegedly abused another individual receiving services, it is necessary to take into consideration the aggressor's judgment and cognitive capabilities to determine whether the act is to be reviewed as an abuse allegation or as a behavioral problem.

All allegations of abuse are to be reported on a standardized form, reviewed, investigated and reported to designated parties according to established procedures.

Abuse is categorized as follows:

1. Physical Abuse - Physical contact which may include, but is not limited to such obvious physical actions as hitting, slapping, pinching, kicking, hurling, strangling, shoving, unauthorized or unnecessary use of personal intervention, or otherwise mishandling an individual receiving service. Physical contact, which is not necessary for the safety of the individual and/or cause discomfort to the individual, may also be considered to be physical abuse.

2. Sexual Abuse - Any sexual contact between an individual receiving services and an employee, volunteer, provider, contractor or consultant is always considered to be sexual abuse and is prohibited.

   Sexual abuse includes any touching or fondling of an individual directly or through clothing for the arousing or gratifying of sexual desires. It also includes causing a person to touch another person for the purpose of arousing or gratifying of sexual desires.

3. Psychological Abuse - The use of verbal or nonverbal expression, or other actions, in the presence of one or more individuals receiving service that subjects the individual(s) to ridicule, humiliation, scorn, contempt or dehumanization, or is otherwise denigrating or socially stigmatizing.

   In addition to language and/or gestures, the tone of voice, such as that used in screaming or shouting at or in the presence of individuals receiving services, may, in certain circumstances, constitute psychological abuse.

4. Seclusion - The placement of an individual in a secured room or area from which he or she cannot leave. This does not include time out room as part of a behavior management plan that meets all applicable requirements.

5. Unauthorized or Inappropriate Use of Restraints - The use of a restraining device to control an individual without written, prior authorization of a physician or the "senior staff member" if the physician cannot be present within 30 minutes.

   The intentional use of a medication to control an individual's behavior that has not been prescribed by a physician for that purpose is considered to be unauthorized use of restraint. In appropriate use of a restraint shall include but is not limited to, the use of a device(s) or medication for the convenience of the Family Care provider or staff, as a substitute for programming or for disciplinary (punishment) purposes.

6. Unauthorized or Inappropriate Use of Time-Out - The use of time out without appropriate permission which include, but is not limited to, the use of the techniques for convenience of a Family Care provider or staff, as a substitute for programming, or for disciplinary (punishment) purposes.

7. Unauthorized or Inappropriate Use of Aversive Conditioning - The use of aversive conditioning without appropriate permission, which includes, but is not limited to, the use of the technique for convenience, as a substitute for programming or punishment.

8. Violation of an Individual's Civil Rights - Any action or inaction that deprives an individual of the ability to exercise his or her legal rights, as articulated in State or Federal Law.

9. Mistreatment - The deliberate and willful determination on the part of an agency's administration or staff to follow treatment practices which are contraindicated by the person's Individualized Program Plan (IPP), which violates an individual's human rights, or do not allow accepted treatment practices and standards in the field of developmental disabilities.

10. Neglect - A condition of deprivation in which individuals receiving services receive insufficient, inconsistent or inappropriate services, treatment, or care to meet their needs; or failure to provide an appropriate and/or safe environment for individuals receiving services. Failure to provide appropriate services, treatment, or care by gross error in judgment, inattention, or ignoring may also be considered a form of "neglect."

Any reportable incident is to be thoroughly investigated by staff designated by the DDSO director or designee. A full investigation of serious incidents or allegation of individual abuse must be carried out immediately by the deputy director (or his or her designee) in conjunction with a trained investigator as needed. All investigations must be documented. No individual may participate in the investigation of any reportable incident or allegation of abuse in which he or she was directly involved, his or her testimony is incorporated, or a spouse, significant other or immediate family member was directly involved. When a serious reportable incident or allegation of abuse is to be investigated, every effort is to be made to have a staff member conduct or review the investigation who is not an immediate supervisor of staff directly involved with the situation or event.

PROCEDURE FOR REPORTING AN INCIDENT:

RESPONSIBILITY	PROCEDURE
Person Noting the Incident	1. Responds to the individual involved. Takes immediate and appropriate action to stop continuation of the incident, if needed.
	2. Provides First Aid or secures treatment from others, if needed.
	3. Informs the Administrator on Call (AOC) or the Administrator on Duty (AOD) of the incident immediately who determines the type of incident (reportable, non reportable, serious reportable and/or allegation of abuse).
Administrator on Call\Duty	4. Uses, on other than business hours, the telephone incident report form to obtain pertinent information regarding the incident reported. This information will be forwarded to the Special Review Committee Chairperson and the director or designee the next business day.
	5. Determines the exact location of the incident and/or alleged abuse.

6. Documents the name(s) and medical condition of the individual. Ensures that the Registered Nurse or physician is called and arranges for physical examination and medical treatment, if necessary.

7. Documents the name(s) of any individual(s) who may have witnessed the event/incident or were in the vicinity when it occurred.

8. Goes immediately to the site or calls a trained investigator to go to the site of the incident.

Director or Designee

9. Initiates and completes applicable information on the OMR-147I and/or A. Signs OMR -147I (space # 30) and/or OMR 147 A (space #30). A note should be entered in the individual's record.

10. Completes any remaining information on the OMR-147I or A. Requests that a physician complete # 19 on the OMR-147I in case of death.

11. Finalizes review Form 147I and\or A to confirm that it is reported correctly and completed.

Director or Designee

12. Ensures needed examination of individual(s). Schedules x-ray and/or consultation as needed. Documents findings and treatment in space # 24; an attachment may be necessary. Notifies director or designee in the event of death of individual.

    a. Reviews and investigates reporting incident.

    b. Attaches investigation report, as necessary.

    c. Provides corrective action, as indicated.

    d. Co-signs in space # 31.

e. Submits Form OMR-147 I to the director's office within 24 hours for serious reportable incidents with preliminary findings; reportable incidents within 48 hours are submitted to the director's office also.

f. Ensures an individual's parent(s), guardian, correspondent, advocate or significant other is notified of the incident or allegation of abuse within 24 hours unless there is written advice from the parent, guardian, correspondent or advocate that he or she does not want to be notified; if the involved individual is a capable adult and objects to such notification being made or if the alleged abuser is one of the aforementioned parties, then notification of the incident or allegation of abuse is not necessary.

13. Notifies, by telephone, OMRDD - Upstate Regional Office or New York City Regional Office for DDSOs in the New York City area.

Chair Special Review

14. Ensures that incidents are logged and numbered accordingly for review by the committee.

15. Completes the quarterly report to be sent to OMRDD Upstate Regional Office or New York City Regional Office for Downstate DDSOs.

December 2000	FAMILY CARE MOVEMENT OR DISCHARGE	Policy 10.1.15

Moving an individual in Family Care to another type of residential setting is to be conducted in conformance with current OMRDD policies and procedures applicable to Community Placement -1 (CP-10) through Community Placement - 9 (CP-9) (see New York State OMRDD *Community Placement Procedures).*

The following may be considered as examples of valid reasons for moving an individual between the Family Care Program and a community residence program. When an individual is discharged or permanently moves to a specialty hospital or a skilled nursing facility or a psychiatric center, the enrollment in the waiver must be terminated through the Tracking and Billing System (TABS).

1. **Discontinuance of Living Situation** - When the Family Care home closes because of an emergency, because the provider is no longer interested or capable, or because OMRDD revoked or suspended the operating certificate.

2. **Individual's Request** - When the individual requests a different living arrangement. If the Team believes that the move will not be detrimental to the individual, every attempt should be made to honor such requests.

3. **Clinical Judgment** - When there is an ongoing or recurrent situation that warrants an individual movement, such as but not limited to:

    a. **Behavior Problems** - When the provider or team finds that he or she is unable to manage the individual's behavior, he or she may request an alternative setting for the individual.

    b. **Lack of Day Programming** - When appropriate day services are no longer available, a change in residence may be warranted.

    c. **Lack of Opportunity** - When the living situation hinders an individual in gaining opportunities for jobs or gaining living skills in shopping, in cooking, in banking and so on, or in any way prevents an individual from reaching optimum level of functioning, the residence may be changed.

d. **Medical or Health Needs** - When a change in the health or medical status of the individual may necessitate a change in living arrangement.

Before such movement occurs, except in emergency situations, there is to be a meeting which includes the Family Care provider, the individual, the advocate, Family Care Home Liaison, Medicaid Service Coordinator and other pertinent staff.

An individual may be discharged from Family Care by choice and offered alternatives based on the individual's rights to any other appropriate and available residence in the community whenever such discharge is in the best interest of the individual. Discharge is to take place in conformance with current OMRDD policies and procedures applicable to community living.

The Family Care provider must immediately seek emergency medical services and follow instructions provided when an individual in a Family Care home dies, or appears to have died. The Family Care provider, as soon as emergency medical services are accessed, must then notify the individual's Medicaid Service Coordinator and the Family Care Home Liaison as well as the administrator on duty, through the 24-hour crisis telephone number, of the individual's death. Staff designated by the chief officer are to assist the Family Care provider in making the necessary arrangements and dispositions.

SECTION 10. 1. 17 INTERSTATE COMPACT

TO BE COMPLETED

SECTION 10.2

STANDARDS FOR FAMILY CARE HOMES

10.2.1 Requirements for Design, Space and Equipment

10.2.2 Safety Requirements: Fire Extinguishers, Smoke Detectors, Steam Pipes and Radiators, Anti-Scald Devices, Ground Fault Interrupters (GFCIs), Testing Standards for Private Wells, Carbon Monoxide Detectors, Asbestos, Swimming Pools and Mobile Homes

10.2.3 OMR- Form 236 ADM Survey for One-And-Two Family Dwellings

10.2.4 OMR - Form 236A ADM Survey for Multiple Dwellings

Rev. August 2004	FAMILY CARE REQUIREMENTS FOR DESIGN SPACE AND EQUIPMENT	Policy 10.2.1

To assure the safety and welfare of individuals residing in Family Care homes, the following requirements must be met:

1. Compliance with Form 236 or Form 236A which is based upon 14 New York Code Rule Regulations (NYCRR) Subpart 635-7.4, and the requirements for existing homes in New York State required by the New York State Uniform Fire Prevention and Building Code or the Building Code of the City of New York. In addition, the physical and accessibility needs of individuals must be considered.

2. Homes are to be sufficient in size to provide adequate and proper living accommodations (living, dining bedrooms and kitchen) for all parties in the household, including the individuals with developmental disabilities (see Table PM-405.5, page 3).

3. No individual's bedroom is to be located in an attic, cellar, stair hall, hallway, or room commonly used for other than bedroom purposes.

4. Primary access and exit from any bedroom must be to a hall, corridor, or other general activity area and not through a bathroom, toilet room, or another bedroom.

5. Adequate bathing and toileting facilities must be provided and kept in a clean and sanitary condition. Toilet rooms and bathrooms must provide personal privacy.

6. Dining space must be adequate in size and equipped to provide for family group seating during meals (see Table PM-405.5 page 3).

7. All rooms occupied by individuals who have moved to Family Care must have natural light, insect screens on front or rear doors, if appropriate, and insect screens in any window that opens for ventilation.

8. Each individual's room must afford as much privacy as possible and be of sufficient size to contain the following furnishings, provided by the Family Care provider:

    a. A suitable, comfortable bed. Cots, futons, and convertible sleep furniture are not to be used. (Bunk beds are permissible for individuals under age 18, if they are the individual's choice, and there are no existing medical conditions, i.e., seizures or sleepwalking, that would result in an accident or present an unsafe situation for the individual sleeping on the top bunk).

b. A bureau or dresser that is accessible to the individual for personal articles.

c. Adequate wardrobe or closet space.

d. A comfortable chair.

9. The Family Care individual may share a bedroom with another Family Care individual of the same sex if the room is of adequate size. An individual and a Family Care provider cannot share a bed or a bedroom. The individual cannot share a bedroom with another member of the provider's family. The only exception is for children with the approval of the Family Care Coordinator or designee and the Medicaid Service Coordinator.

10. The home must have telephone service. *Cellular phones may not be used as the primary telephone service in the home.*

11. The home must be equipped with smoke detectors and fire extinguishers in accordance with the National Fire Protection Association (NFPA) 10, and the equipment must be approved and labeled by the Underwriters Laboratories (UL).

12. The use of portable or temporary space heaters as the sole source of heat is prohibited. However, exceptions for cause for temporary use may be granted where the commissioner or his or her designee has determined that the safety and welfare of the individuals residing in the home has not been compromised.

13. The home must be equipped with anti-scald devices on ALL faucets/showers that are routinely used by the individual regardless of the assistance that the individual requires. An anti-scald device is NOT needed on a kitchen sink if the individual is NOT capable of using the sink. A tempering valve may also be used if it is more feasible.

14. The home must be equipped with Ground Fault Circuit Interrupters (GFCI) at electrical outlets within six feet of bathroom and kitchen sink locations routinely used by individuals. A GFCI must also be installed in other areas that may pose a safety hazard to individuals in the home, such as outdoor electrical outlets used for pool pumps.

15. Any hazardous conditions that present a threat to an individual's safety or welfare must be repaired in a timely manner.

16. The provider must ensure the maintenance and/or cleaning of any heating, air conditioning and/or air filtration equipment. Equipment must be tagged to certify inspection.

17. The Family Care provider must notify the sponsoring agency immediately of the anticipated or actual termination of any service vital to the continued safe operation of the home or the health of individuals living in the home. This includes but is not limited to the following services: telephone, electric, gas, fuel, water, septic tank, heat, air-conditioning, smoke or heat detection equipment or sprinkler systems.

SPACE STANDARDS

The following space standards for existing homes are from the BOCA National Property Maintenance Code, 1993 edition. HUD adopted this national standard in 1995 for use in all HUD-financed housing. It is neither a regulation nor a policy of OMRDD, but is included here for information purposes only for those initial certification situations where direction is needed as to what is presently considered minimum occupancy limitations.

PM-405.3 Area for sleeping purposes: Every room occupied for sleeping purposes by one occupant must contain at least 80 square feet of floor area, and every room occupied for sleeping purposes by more than one individual must contain at least 50 square feet of floor area for each occupant thereof.

Table PM-405.5
Minimum Occupancy Requirements

Space Guideline	Minimum Occupancy in Square feet		
	1 - 2 occupants	3 - 5 occupants	6 or more
Living Room*	No requirements	120	150
Dining Room*	No requirements	80	100
Kitchen	50	50	60
Bedrooms	Will comply with Section PM-405.3		
See Section 405.6	For combined living room and dining room spaces.		

FOR OTHER ISSUES NOT COVERED BY THE CHECKLIST

There are innumerable aspects to a Family Care home that make it impossible to cover every potential scenario in a checklist format. Many issues need to be looked at on a case-by-case basis, and must not be dealt with using a "yes" or "no" approach. One example would be a potential Family Care home that contains a very small bedroom, say 9' x 9', for a potential resident.

Instead of automatically rejecting the room, and thus the entire family as providers, it may be helpful to form a standing committee with staff representing a variety of perspectives (Family Care Coordinator, a Family Care provider, a Medicaid Service Coordinator, Family Care Home Liaison, Quality Assurance, Fire and Safety, etc.,). This group may be asked to consider that situation, with the needs of the specific individual being considered for that home, and come to a balanced decision as to whether or not the room is acceptable.

This committee approach to building and/or use issues may result in decisions not being too conservative (i.e., the room is eight square feet too small so it cannot be used) vs. too lenient (i.e., it's not on the checklist so it's not your responsibility to consider the problem and/or comment).

This approach may also do away with the old OMRDD concept of a "waiver." This term is fraught with confusion, as some building issues are OMRDD regulations, which can be waived, by the commissioner or his or her designee. Others are regulations from the New York State Building Code, which OMRDD has no authority to waive. Yet other issues are simply problems inherent in older private homes and/or the make up of people who live there, which require careful thought and consideration on a case-by-case basis.

All Family Care providers are to observe the following safety requirements:

1. A fire evacuation plan must be developed and implemented, with fire drills taking place no less than on a monthly basis at different times during the day with family members living in the home participating. The provider must maintain a copy of monthly fire drills to include the time required to evacuate all individuals.

2. All equipment used for heating, lighting, and cooking must be safe, appropriate, and approved by the Underwriters Laboratories (UL). Due to the potentially hazardous conditions which may result when using equipment for heating, lighting, and cooking, care is to be employed when using such items.

3. The use of portable or temporary space heaters is prohibited. However, exceptions for cause for temporary use may be granted where the commissioner or his or her designee has determined that the safety and welfare of the individuals residing in the home has not been compromised.

4. All dangerous household products, flammable liquids, chemicals, caustics, toxic items, and highly combustible materials are to be stored in a safe manner.

I. Fire Extinguishers:

The Family Care provider must ensure that the fire extinguisher is accessible and either mounted with the brackets that were supplied or placed on a shelf with directions visible. One fire extinguisher must be maintained in or near the kitchen. Additional extinguishers may be required, and provided by OMRDD when warranted. A trained DDSO code enforcement officer or other trained DDSO staff determines if conditions exist which would necessitate the installation of more than one fire extinguisher in a home. The DDSO trained staff monitors by visual inspection on a periodic basis that the fire extinguisher is available, in its designated place, and it has not been actuated or tampered with.

Fire extinguishers are to be type 2A 10 BC minimum (approved and labeled by the Underwriters Laboratories, and periodically monitored by DDSO Staff). One extinguisher must be in or adjacent to the kitchen.

1. Fire extinguishers must be provided to **newly certified** Family Care providers by the sponsoring agency at no cost to the provider. Maintenance (repairs and replacement) of fire extinguishers will be the financial responsibility of the Family Care provider.

2. Fire extinguishers must be pressure checked as recommended by the manufacturer or no less than every ten years and replaced at the provider's expense when not adequately charged.

II. Smoke Detection:

All Family Care homes must comply with the requirements for smoke detection equipment in accordance with the building code in effect when the home was first certified. These requirements are:

1. A single-station, smoke-detecting alarm device is to be installed so as to avoid dead air space, detect smoke and activate alarm, be reasonably free from false alarm, and provide visible indication that the alarm is energized. A single-station, smoke-detecting alarm device means an assembly comprising a photoelectric or ionization type of smoke detector, control equipment and audible alarm in one unit, which upon detection of smoke, activates the alarm.

2. The alarm must be clearly audible in adjacent sleeping spaces with intervening doors closed.

3. At least one single-station smoke-detecting alarm device is to be provided adjacent to sleeping spaces, and must be located on or near the ceiling.

4. A single device must be installed in sleeping areas of the home built **after July 1995.**

5. All devices and wiring must be UL approved.

6. If the device is a plug-in unit or directly wired, there is to be no intervening wall switch and the device must be equipped with a retaining clip.

7. Replace every 10 years, when testing indicates or as the manufacturer recommends.

In addition, the Family Care home is to comply with the following requirements:

1. At least one device is to provide an alarm for the general activity areas of the home but not in the kitchen or near any corners. In a two-story home, this device is to be close to the stairway leading to the second floor sleeping quarters.

2. Any Family Care home with its own basement is to have a device located at the head of the basement stairs. However, the smoke detector should be placed within 6 feet of the bottom of a stairway that is closed at the top, rather than the top, to compensate for the increased dead air space in the enclosed stairwell.

3. Additional smoke detection devices may be required by OMRDD when warranted.

4. The final locations of the devices must be approved by OMRDD's local DDSO.

5. The testing maintenance and upkeep of smoke detection devices, including replacement, are the responsibility of the Family Care providers in accordance with NFPA #72, 1996 *Household Fire Warning Equipment*, available from the local DDSO.

6. Family Care homes providing services to persons with special needs (hearing or visually impaired) must be equipped with smoke detection devices designed specifically for the hearing or visually impaired. The sponsoring agency is responsible for purchasing and ensuring the installation of these devices.

7. Smoke detection devices for newly certified Family Care homes must be provided through the sponsoring agency. Additional smoke detection devices which may be required, if the certified capacity of an existing Family Care home is increased, will be provided by OMRDD. Replacement is the responsibility of the Family Care provider. However, those devices for persons with special needs (hearing or visually impaired) will be replaced by the DDSO.

8. Trained DDSO staff must ensure proper placement of a smoke detection device(s) and inspections for compliance with regulations and policy.

III. Steam Pipes and Radiators:

Steam pipes and radiators that may present a burn hazard to certain individuals (children, elderly, blind) must be shielded. If the application of this provision results in unreasonable hardship upon the provider, the local DDSO staff must work with the provider to meet the specific safety provision.

IV. Anti-Scald Devices:

The home must be equipped with anti-scald devices on ALL faucets/showers that are ROUTINELY used by the individual regardless of the assistance that the individual requires. An anti-scald device is NOT needed on a kitchen sink if the individual is NOT capable of using the sink.

In situations where anti-scald devices have failed or where there is a need to have a large number of anti-scald devices in the home, the Family Care provider may choose to install a tempering valve. The tempering valve may be installed at any point in the hot water line to any faucet or directly off the hot water tank.

For shower areas, providers may also choose to purchase a hand held shower device with an anti-scald device built into the showerhead.

The temperature of the hot water from the faucet/shower head must be tested on a ROUTINE basis.

A waiver may be requested by a Family Care provider when it has been determined that it would be cost prohibitive to provide the protection of an anti-scald/tempering device or the approval of the landlord cannot be obtained. In these situations, all alternatives must be explored prior to the issuance of a waiver and a statement from the landlord or plumber is required. The waiver must include a plan to ensure the individual's safety in the home. The provider must sign the waiver.

Reimbursement for the purchase and installation of tempering valves and anti-scald devices must follow the reimbursement agreement currently in effect. In situations where the devices have failed and the warranty period has expired, the sponsoring agency may choose to reimburse the provider for the replacement of these devices following the reimbursement agreement currently in effect.

V. Ground Fault Circuit Interrupters:

The home must be equipped with Ground Fault Circuit Interrupters (GFCIs) at electrical outlets within six feet of bathroom and kitchen sink locations routinely used by individuals.

A GFCI must also be installed in other areas that may pose a safety hazard to individuals in the home such as outdoors electrical outlets used for pool pumps at the discretion of the DDSO

In all cases, the GFCI must be tested with a GFCI tester to ensure it is correctly wired and operating properly during safety inspections of the home.

A Family Care provider may request a waiver when a GFCI cannot be installed in a Family Care home. Prior to issuance of the waiver, the DDSO must have a written statement from an electrician stating that a GFCI could not be installed in the home. The waiver must include a plan to ensure the individual's safety in the home and the provider must sign the waiver.

VI. Testing Standards for Private Wells:

The following well water testing is to be used for Family Care homes that are certified by OMRDD, as well as for homes approved for respite services. Only the initial testing is mandatory. All other testing is to be done on an as needed basis.

A. Initial - the water is to be tested in accordance with the, local Department of Health or authority having jurisdiction, requirements for new private homes. The provider is required to follow the local recommendations as indicated by the test results.

B. Sodium - For individuals who are on sodium free or sodium restricted diets. If the test results are positive, corrective measures must be taken to ensure that the sodium level falls within the acceptable limits. This test should be repeated every two to three years.

C. Lead -If the local utility has been notified by the Environmental Protection Agency that there is a lead problem; the provider is to follow local recommendations as indicated by the test results.

D. Unspecified Organic Compounds - Test must be conducted specific to any seasonal application of organic compounds for wells located near a farm, old underground tanks, and landfills, where there may be a high probability of contamination from pesticide spraying or infiltration from contaminants. The provider must follow local recommendations as indicated by the test results, including a retesting schedule.

E. Heavy Metals-Testing should include mercury, lead, arsenic, and others for wells located near a landfill. The provider must follow local recommendations as indicated by the test results.

It is the responsibility of the sponsoring agency to ensure that retesting is completed in a timely manner. The costs of the initial testing are the responsibility of the Family Care provider. The costs of testing for lead, unspecified organic and heavy metals should be the responsibility of the provider since it benefit the entire home to correct the problem. However, if the testing creates a financial hardship, the sponsoring agency may assist, where applicable.

VII. Carbon Monoxide Detectors:

Experts are divided over requiring carbon monoxide detectors in newly built homes. The best defense is an annual inspection of heating units by a heating contractor or a technician from the local gas utility. Inspectors can spot flaws by sight and use hand held sniffers to detect carbon monoxide. This does not preclude a provider from installing a detector.

VIII. Asbestos:

If asbestos exists in a Family Care home, the sponsoring agency needs to determine whether or not the asbestos is firmly locked-in or contained. In instances where asbestos fibers are loose and are being actively distributed, the Family Care provider will be responsible for having the friable asbestos encapsulated or removed. However, if removal creates a financial hardship, the sponsoring agency may consider assisting the Family Care provider, where applicable using the loan procedure.

IX. Swimming Pools:

Where there are no local ordinances regarding the enclosure of swimming pools, the Family Care provider must contact the DDSO, prior to installing the pool to ensure the safety of the individuals living in the home. If the pool has been installed, the provider must install an enclosure to prevent the individual from accessing the pool without appropriate supervision. Under no circumstance, must an individual be left unsupervised in the swimming pool for any amount of time. Individuals placed in homes with a swimming pool must have in place a water safety assessment.

X. Mobile Homes:

All mobile homes must meet the guidelines specified in 14 NYCRR Part 635, *General Quality Control and Administrative Requirements Applicable to Facilities Certified by the* Office of Mental Retardation and Developmental Disabilities.

State of New York OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES OMR- FORM 236 ADM. Rev. 12/00	FAMILY CARE HOME SURVEY FOR ONE-AND-TWO FAMILY DWELLINGS

Date _____ Inspector _____ Family Care Applicant\Provider _____

Address _____ Zip Code _____

Sponsoring Agency _____ Family Care Applicant\Provider Telephone Number _____

☐ Initial Certification ☐ Recertification Have there been changes to the home since the last inspection? Yes ☐ No ☐

Approximate Age of the Home _____ Attach a floor plan upon initial certification, and include dimensions of each bedroom and occupant(s) of each bedroom.

Gross Square Feet Per Floor: Basement _____ First Floor _____ Second _____

PLEASE NOTE: If the home undergoes new construction additions or other alterations requiring a building permit, a copy of the building permit and certificate of occupancy from the local building department must be obtained.

A. RESIDENT SLEEPING SPACES	YES	NO	IF NO, COMMENTS
1. Is there access to each bedroom without going through another bedroom?**			
2. Are the attic, stair hallway(s), hallway(s), or any room(s) commonly used for other than bedroom purposes free of beds? **[635 -7.4(a)(2)(iii)(e)(ii)]***			
3. a. Is natural light and ventilation provided in each bedroom?** b. Is there a window that can be opened in each bedroom for use in an emergency?			
B. HABITABLE SPACES (LIVING, DINING, SLEEPING)			
4. Do habitable spaces have natural light and ventilation?**			
5. Do habitable spaces have electric light appropriate for intended use?**			
6. Are all habitable spaces no more than 4'0" below average grade?**			

C. NON-HABITABLE SPACES (pantries, toilet, laundry, storage, utility, hallways and stairways, garages)			
7. Are bathrooms arranged to provide privacy? **[635 -7.4(b)(1)(I)]***			
8. Do non-habitable spaces have electric light appropriate for intended use?**			
9. Are kitchenettes, bathrooms and toilet rooms provided with natural or mechanical ventilation?**			
10. If there is glass in showers and tub enclosures, is it safety glass?			
D. ALL SPACES			
Electrical			
11. Is wiring firmly supported or in a conduit?**			
12. Are all fuses and circuit breakers of the proper size?**			
13. Are wires free from fraying or insulation cracking?**			
14. Are there enough outlets to prevent makeshift wiring and use of extension cords?**			
Heating, Ventilating, Air Conditioning and Fuel Storage			
15. If a wood stove exists, does it meet the installation standards of NFPA 211, or the manufacturer's installation requirements?			
16. Do steam radiators and pipes have protective shields? **[635 -7.4(a)(2)(iii)(g)]***			
17. a. Is heating equipment and fuel storage safe and operable?** b. If a wood stove/fireplace exists, is it maintained in a safe manner? c. Are there portable space heaters (except for emergency use with approval)? If yes, please comment. **[635 -7.4(a)(2)(iii)(b)]***			
18. Do portable fire extinguishers meet NFPA 10 and are UL approved and labeled? **[635 -7.4(a)(2)(iii)(f)]*** Note: For clarification, extinguisher to be type 2A 10BC (as a minimum). One extinguisher is to be in or adjacent to the kitchen.			

Stairs	YES	NO	IF NO, COMMENTS
19. Do stairways have a handrail on at least one side?**			
20. a. Are smoke detectors installed in each corridor adjacent to sleeping rooms? Or in sleeping areas of the home built after July 1995? **[635 -7.4(a)(2)(iii)(e)(l)]***			
b. Are smoke detectors installed in corridors or in an adjacent open area, such as a living room, dining room or recreation room, at a maximum of thirty feet on center and no more than 15 feet from a wall? **[635 -7.4(a)(2)(iii)(e)(1)]***			
c. Is a smoke detector installed at the head of each open stairway located within the home, or within six feet of the bottom opening of a stairway that is enclosed at the top? **[635 -7.4(a)(2)(iii)(e)(2)]***			
d. Is at least one smoke detector installed at the head of the basement stairs? **[635 -7.4(a)(2)(iii)(e)(3)]***			
e. Is the basement partitioned? If so, are there adequate smoke detectors installed? **[635 -7.4(a)(2)(iii)(e)(3)]***			
f. Is the accessible and usable attic partitioned? If so, are there adequate heat detection units installed? **[635 -7.4(a)(2)(iii(e)(iii)]***			
g. Are all smoke detectors clearly audible in sleeping areas with intervening doors closed?**			
Environmental			
21. Do ventilation windows have removable screens?			
22. Does the home have telephone service? **[635 -7.4(a)(2)(iii)(c)]***			
23. If the water supply is private, has the water been tested at least once in accordance with Department of Health (or authority having jurisdiction) requirements for private homes?			

Environmental Cont'd	YES	NO	COMMENTS
24. Are general plumbing systems safe, sanitary and in serviceable condition?**			
25. Is the door(s) from the house to an attached garage tight fitting with a self closing device?			
26. Are structural members protected and maintained to resist and prevent deterioration?**			
27. Is the dwelling free of obvious safety hazards? **[635 -7.4(b)(iv)]***			
28. Is there one toilet, sink and tub\shower for every six people who live in the home?			

Exterior Property	YES	NO	IF NO, COMMENTS
29. If there is an in ground pool of more than 24" in depth on the property, is there an approved enclosure or equivalent that controls access? (The enclosure may surround either the pool area or the property.)**			
30. Are grounds free of obvious safety hazards?**			
31. Is groundwater appropriately drained to protect buildings?**			
32. Is the home equipped with the required: a. GFCI at bathroom and kitchen sinks? b. Anti-scald device at tub\shower and sink?			
33. It is recommended that the following issues be considered, as appropriate or indicated, based on the conditions of either the building or people in the home. Examples (not all inclusive): Grab bars, Strobe lights, bed shakers Environmental testing: Asbestos Radon Insect Infestation Lead paint			
Mobile Homes			
34. a. Did the provider furnish a copy of verifying documentation that the home is a 1976 or newer model?			
b. Is the Federal Housing, Education and Welfare seal (a red metal seal attached to home at time of construction) installed on the outside of the house, verifying that the unit was constructed to HUD standards?			
c. Can the applicant provide a copy of the occupancy certification certifying compliance with NYS UFPBC Part 1223 Installation Procedures?			

E. OTHER ISSUES	Comments

GENERAL COMMENTS:

Inspected by _____

_____ Signature _____ Date

Reviewed by _____ _____ Date

Comment(s) _____

* OMRDD Regulatory requirements which must be met.
** NYS Uniform Fire Prevention and Building Code. Subchapter F.

FAMILY CARE INSPECTION REPORT
PLAN OF CORRECTION

Family Care Provider _____ Address _____

_____ Inspection Date _____

CHECKLIST NUMBER	PLAN OF CORRECTION	PLANNED COMPLETION DATE	DATE COMPLETED

Form 236-Rev.12\00
cc. Family Care Provider
Provider File

_____
Signature of Family Care Provider Date

_____
Signature and Title of Person Responsible for Corrective Action Report

_____
Signature and Title of Person Responsible for Reviewing Plan of Correction

State of New York OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES OMR-FORM 236 A-ADM Rev. 10/00	FAMILY CARE HOME SURVEY FOR MULTIPLE DWELLINGS

Date _____ Inspector _____ Family Care Provider/Applicant _____

Address _____ Zip Code _____

Sponsoring Agency _____ ( ) Family Care Provider/Applicant Telephone Number _____

☐ Initial Certification ☐ Recertification Have there been changes to the home since the last inspection? ☐ Yes ☐ No

Type of construction _____ Number of stories _____ Approximate age of building _____ years.

Type of multi-family unit _____ Mixed-use _____ 3 - 4 units _____ 4-8 units _____ Over 8 units

Approximate gross square footage of residence _____ square feet. What floor is residence on? _____

Name of people who live in the residence _____ _____

_____ _____ _____

_____ _____ _____

Attach a floor plan upon initial certification, include dimensions of each bedroom and occupant(s) of each bedroom:

Bedroom 1 _____ Bedroom 2 _____ Bedroom 3 _____

Bedroom 4 _____ Bedroom 4 _____ Bedroom 5 _____

A. CONSTRUCTION TYPE	YES	NO	COMMENTS
1. Are dwelling units separated by fire-rated construction in accordance with the building code requirements of the community for existing multiple dwellings?			
2. If this is a multi-use building, is there an appropriate rated separation between the other occupancy and the residence?			
B. EXITS	**YES**	**NO**	**COMMENTS**
3. Are there at least two separate means of egress from the corridor outside of the dwelling unit? ***			
4. Are all stairways and corridors illuminated? **			
5. Is there emergency lighting provided in exits?			
6. Are exit and directional signs illuminated? **			

CONSTRUCTION TYPE CONTD.	YES	NO	COMMENTS
7. a. Are fire escapes or exterior stairs used as a required means of exit? b. If yes, do they comply with local code requirements? **			
8. If exit corridor is longer than 100 feet, is there a smoke stop?			
9. Are all exits unlocked or unfastened so that there is free, unobstructed departure from inside the building?			
10. Do dwelling unit corridor doors have self-closing devices?			
11. Are corridors, walls and doors fire-rated in accordance with building codes?			
12. If exit stairway from upper floors continues to a basement, is there a mechanism to prevent unintentional exit travel to the basement?			
C. CERTIFIED BEDROOMS	**YES**	**NO**	**COMMENTS**
13. Do all bedrooms have a minimum width of 7'0"?			
14. Do the windows open onto an open space that allows escape from a fire?*			
15. Is there access to each bedroom without going through another bedroom?**			
16 Are the attic, stair hallway(s), hallway(s), or any room(s) commonly used for other than bedroom purposes free of beds?*			
17. Is natural light and ventilation provided in each bedroom?**			
18. Is there a window that can be opened in each bedroom for use in an emergency? **			
19. Do habitable spaces have natural light and ventilation?**			
20. Do habitable spaces have electric light appropriate for intended use?**			
21. Are all habitable spaces no more than 4'0" below average grade?**			

E. NON-HABITABLE SPACES (pantries laundry, bathrooms, storage, hallways)?	YES	NO	COMMENTS
22. Are bathrooms arranged to provide privacy?*			
23. Do non-habitable spaces have electric light appropriate for intended use?**			
24. Are kitchens and bathrooms provided with natural or mechanical ventilation?**			
25. If there is glass in showers and tub enclosures, is it safety glass?			
F. ALL SPACES	**YES**	**NO**	**COMMENTS**
26. Is wiring firmly supported or in a conduit?**			
27. Are all fuses and circuit breakers of the proper size?**			
28. Are wires free from fraying or insulation cracking?**			
29. Are there enough outlets to prevent makeshift wiring and use of extension cords?**			
G. HEATING, VENTILATING, AIR CONDITIONING AND FUEL STORAGE	**YES**	**NO**	**COMMENTS**
30. Do steam radiators and pipes have protective shields? *			
31. Is heating equipment and fuel storage safe and operable?**			
32. Are there portable space heaters (except for emergency use with approval)?* If Yes, please explain under comments.			
H. STAIRS	**YES**	**NO**	**COMMENTS**
33. Do stairways have a handrail on at least one side?**			

I. FIRE SAFETY	YES	NO	COMMENTS
34. Are smoke detectors installed in each corridor adjacent to bedrooms?*			
35. Are smoke detectors installed in corridors or in an adjacent open area, such as a living room or dining room, at a maximum of thirty feet on center and no more than 15 feet from a wall?*			
36. Is the fire alarm system centralized?			
37. Do portable fire extinguishers meet NFPA 10 and are UL approved and labeled?* Note: For clarification, extinguisher to be type 2A 10BC (as a minimum). One extinguisher is to be in or near the kitchen on that floor).			
J. ENVIRONMENTAL	**YES**	**NO**	**COMMENTS**
38. Do ventilation windows have removable screens?			
39. Does the home have telephone service?*			
40. Is there an adequate supply of water (both quantity and temperature)? **			
41. Are the general plumbing systems safe, sanitary and in serviceable condition?**			
42. Is there one toilet, sink and tub/shower for every six people who live in the home?			
43. Are structural members protected and maintained to resist and prevent deterioration?**			
44. Is the dwelling free of obvious safety hazards?*			
45. Are grounds free of obvious safety hazards?**			
46. Is the home equipped with: a. GFCI at bathroom and kitchen sink? b. Anti-scald device at tub\shower and sink routinely used by the individuals?			

ENVIRONMENTAL CONT'D	YES	NO	COMMENTS
47. It is recommended that the following issues be considered, as appropriate or indicated, based on the conditions of either the building or people in the home. Examples (not all inclusive): Grab bars, Strobe lights, bed shakers Environmental testing: Asbestos Radon Termites Lead paint			

K. OTHER ISSUES	COMMENTS

GENERAL COMMENTS

Inspected by _____ Date _____

Reviewed by _____ Date _____

Comments _____

_____

_____

* Regulatory and OMRDD Requirement

** New York State Uniform Fire Protection and Building Code

*** Not a Requirement, but must be Seriously Considered

Copy: Provider File

FAMILY CARE INSPECTION REPORT PLAN OF CORRECTION

Family Care Provider _____ Address _____

_____ Date of Inspection _____

CHECKLIST NUMBER	PLAN OF CORRECTION	PLANNED DATE OF COMPLETION	COMPLETION DATE

Rev. 10/00 Form 236A-ADM

cc. Family Care Provider
Provider File

Signature of Family Care Provider _____ Date _____

Signature and Title of Staff Responsible for Corrective Action _____

_____

Signature and Title of Staff Responsible for Reviewing Plan of Correction _____

_____

SECTION 10.3

CERTIFICATION AND RECERTIFICATION

10.3.1	Initial Certification Procedures
10.3.1A	OMR - LS 22 Application for Family Care Home Certification
10.3.1B	Physician's Approval Form
10.3.1C	Employment Reference
10.3.1D	Personal Reference
10.3.1E	School Reference
10.3.1F	Child Abuse Prevention Act Requirements for Background Checks of Applicant(s) and Other Adults Residing in the Home
10.3.1G	Statement of Prohibition of Abuse and Neglect
10.3.1H	Critical Driver Certification Program
10.3.1I	Finger Printing Process
10.3.2	Employees as Providers
10.3.3	Homes Used by More Than One Agency
10.3.4	Recertification for Renewal
10.3.4A	Increased Capacity
10.3.4B	Vacancies
10.3.5	Family Care Home Certification and Recertification Data Sheet
10.3.6	Adequacy of Resources

In accordance with Section 16.05 of the New York State Mental Hygiene Law, and at the time of initial certification, OMRDD through its local DDSO must examine the applicant against the concepts and requirements set forth in the principles of compliance. The *LS 22 Application for Family Care Home Certification* must be made by the person(s) responsible for operation of the Family Care home. There is no initial or renewal certification fee, and each Operating Certificate can be valid for up to three years unless otherwise stated or terminated. The certified capacity, to include respite bed(s), must be stated on the Operating Certificate.

Anyone providing Family Care services is to do so only after receiving an Operating Certificate issued by OMRDD, through the local DDSO. This certificate is a document that tells the public the provider has been authorized by OMRDD to operate a Family Care home.

OMRDD will issue an original Operating Certificate to:

a. A person or persons, other than the spouse of the individual being served, age 21, without regard to marital status, of either sex, provided all requirements of certification are met.

b. A person who is not the **individual's natural or adoptive parents,** except for Willowbrook Class Members, pursuant to the decision, and other order of the United States District Court, Eastern District of New York, dated January 2, 1980 in *New York State Association for Retarded Citizens et al. and Parisi, et al. v. Carey, et al.*

c. A provider who owns, rents, or leases a house or a mobile home or an apartment.

d. A specific address. A Family Care provider may not operate more than one Family Care home, and must reside at the premises which are to be the Family Care home.

e. A new Family Care home certified *after July 1986* for a capacity of no more then four individuals.

a. The applicant(s) and all adults living in the home have been cleared through the State Central Register. If clearance has not been received in a timely manner, the DDSO director or his or her designee, in an emergency, may move to certify the home and the provider. The provider must, however, be informed that if a

case has been "founded" for child abuse on any adult in the home, OMRDD has the right to rescind the Operating Certificate.

g. A person whose home has met all building code standards of *the current Form 236 ADM. MR Survey for Single Dwellings or the current Form 236A Survey for Multiple Dwellings.*

h. A person whose home has been modified, if necessary, to meet the individual (s) physical, accessibility, sensory and behavioral needs.

i. A person whose home is large enough to provide adequate and proper living accommodations for **ALL** of the people in the household, including any individuals with developmental disabilities.

j. A person who has received the initial thirty (30) hours of training required (ref. OMR-Family Care Policy 10.13) as a prerequisite to issuance of the Operating Certificate.

k. A person who has completed and signed the Statement of Prohibition of Abuse and Neglect.

l. A person who has not been convicted of a Class A, B,or C felony within the last ten years.

The guidelines for certifying a new Family Care home are as follows:

1. The applicant(s) directs inquiry to the DDSO or sponsoring agency in writing.

2. The DDSO or sponsoring agency Family Care staff or DDSO designee, contacts interested party (ies) to schedule an interview. The interview is conducted:

   a. to explain the Family Care Program.

   b. to outline the responsibilities of a Family Care provider (ref. OMR Family Care Policy 10.6).

   d. to provide a brief overview of applicable 14 New York Codes Rules Regulations Parts 624, 633, 687 and Section 635-7.4.

   e. to explain the certification process including the State Central Register check.

e. to explain the Critical Driver's program, and

f. to explain the Finger Printing process through the Division of Criminal Justice Services.

3. If the applicant (s) is interested in pursuing certification, the Family Care Coordinator or designated staff:

   a. Schedules and conducts a home visit(s) to interview the applicant(s), and other members of the household. This visit is the basis for the home evaluation and narrative.

   b. Arranges with safety officer or code enforcement officer or DDSO certification staff, a fire and safety inspection in accordance with 14 NYCRR Section 635-7.4, and completion of *Form 236 ADM Family Care Home Survey For One-and-Two Family Dwellings or Form 236A for Multiple Dwellings,* which must include a floor plan to document at a minimum the following:

      i. Relationship of rooms to one another.

      ii. Approximate size of bedrooms.

      iii. Approximate size of living room and dining room (must be adequate for entire household).

      iv. Labeled sleeping arrangements of the household.

The DDSO or sponsoring agency staff:

4. Checks the applicant and all adults residing in the home through the Office of Children and Family Services (OCFS) State Central Register.

5. Provides, after receipt of the State Central Register Clearance, the *LS 22 Application For Family Care Home Certification* to the applicant(s).

The applicant(s):

6. Returns one notarized and completed *Form LS 22 Application for Family Care Home Certification,* completed Physician's Statement, and other testing and immunization

requirements consistent with OMRDD's current policy for persons providing direct care to individuals with developmental disabilities.

The DDSO staff begins application process with the applicant(s) including:

a. Contacting the names of three people, who are not related to the applicant(s), and has known the applicant for at least three years, and requesting **written** letters of recommendation.

b. Ensuring receipt of a Physician's Statement (see *10.3.1B-Physician's Approval Form).*

c. Verifying employment, if applicable (see *10.3.1C-Employment Reference*).

d. Requesting reports from other agencies, if previously certified to care for people.

e. Ensuring the completion of the Finger Printing process.

f. Ensuring that the provider has a valid driver's license or has access to transportation as needed for medical appointments and community inclusion activities. If the provider is a licensed motor vehicle operator, enroll in Critical Driver Certification Program through the Department of Motor Vehicle (DMV).

The DDSO or sponsoring agency staff:

7. Schedules, upon receiving the *LS 22, Application for Family Care Home Certification* and all necessary documents, a follow-up interview with the applicant (s) to clarify any questions, and/or acquire additional information. Advises the applicant(s) of any safety deficiencies that require correction, and completes Plan of Corrective Action, when appropriate.

8. Schedules a re-inspection visit to verify completion of work as required.

9. Reviews final packet for accuracy and completeness.

10. Meets with the applicant(s) to review requirements, answer any questions, etc.

The applicant (s):

11. Completes the required thirty (30) hours of initial training (ref. *Family Care Manual* Policy 10.13). (For a provider unable to satisfy the requirements of CPR training, a notation must be placed in the provider's file).

The Family Care Coordinator or designee:

12. Makes written recommendation(s) and forwards the certification packet to DDSO Certification staff who reviews, and makes written recommendation(s) to the Director or designee (non-Family Care Staff).

13. Prepares and sends letter, and the original operating certificate to the provider(s) subsequent to the approval of the Director or designee (non-Family Care Staff).

14. Informs the applicant in writing of any deficiencies still needing corrections prior to the approval of the DDSO director or designee (non-Family Care Staff).

15. Completes OMR FC Family Care Home Registration Form, and forwards (E-MAIL) to COOPCERT (ref. Family Care Policy 10.3.5)

16. If the applicant(s) is denied, the DDSO director or designee, sends written justification, with a copy to the Office of Counsel, as to why the applicant(s) is not being certified. The director or designee (non-Family Care Staff) informs the applicant(s) of any recourse he or she has to request further meeting regarding the status of the application.

Statement of Prohibition of Abuse and Neglect

I, _____, Family Care Provider for _____ DDSO or ASFC, have read and fully understand the contents outlined in 14 NYCRR Part 624 Reportable Incidents, Serious Reportable Incidents, and Abuse. I further understand that I cannot, and will not, in any manner, cause harm to any individual living in my home. I further understand that I must, within 24 hours report all incidents, e.g., abuse, neglect, injury, and/or leave without consent to the local sponsoring agency.

Failure on my part, any member of my household, or substitute provider, arranged by me or the sponsoring agency, to uphold the guidelines provided in 14 NYCRR Part 624, or OMRDDs policies and procedures, may constitute the suspending or revoking or terminating of my operating certificate.

Signed: _____ Date _____
Family Care Provider

Signed: _____ Date _____
Family Care Provider

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

_____
(Date)

(Applicant's name and address)

Dear _____:

It is the decision of the Office of Mental Retardation and Developmental Disabilities (OMRDD), pursuant to Section 16.05 of the Mental Hygiene Law, to deny your application for an operating certificate to operate a Family Care home at the above address. This decision is being taken after a careful review of your application by this office.

This action is based in part but not limited to the following finding(s):

You have the right to an administrative hearing to appeal this denial of your application for an operating certificate. You also have the right to be represented by an attorney at such a hearing. In order to have such a hearing you must request it in writing, within 10 days of your receipt of this letter, to:

Paul R. Kietzman
General Counsel
New York State Office of Mental Retardation
and Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

Your written request for a hearing **must include a copy of this letter.** You have the right to have this **hearing within 40 days** of your written request.

Sincerely,

_____
Director

cc. Office of Counsel

Rev. 5/98
CALP-100

State of New York OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES OMR LS 22 Application for FAMILY CARE HOME CERTIFICATION (Rev. 10/05)	Instructions to Applicant(s): ▪ Applicant(s) with assistance of Sponsoring Agency staff, completes, signs and have notarized one (1) copy of the LS 22. Please Note: LS 22 must be used upon Recertification when there are changes in or to the home. ▪ OMRDD will conduct the necessary inspections and evaluations of the home. ▪ If approved, an Operating Certificate may be valid for a period of up to three (3) years.

(For Sponsoring Agency Use Only)

Initial Certification: Date of Certification ___/___/___ State Sponsored ___ Agency Sponsored ___

Recertification: Date of Recertification ___/___/___ Agency Name/DDSO _____

I. PROVIDER INFORMATION

A. Name of Applicant _____

Employed by Sponsoring Agency ☐ Yes ☐ No

Source of Income _____

Yearly Income $_____

Name of Co-Applicant _____

Employed by Sponsoring Agency ☐ Yes ☐ No

Source of Income _____

Yearly Income $_____

Attach an employment history, together with a signed release for employment verification.

B. Address _____

Street City County Zip Code

Mailing Address if different _____

Street City County Zip Code

C. Telephone Number(s)

Land Line (Home Phone) _____ Cellular _____

D. Current Marital Status ☐ Married ☐ Never Married ☐ Separated ☐ Widowed ☐ Divorced

Social Security # Applicant _____ Social Security # Co-Applicant _____

E. Religion

☐ Protestant ☐ Catholic ☐ Jewish ☐ Jehovah's Witness ☐ Muslim ☐ None ☐ Other, specify _____

F. Primary Language

☐ English ☐ Spanish ☐ Sign ☐ Other spoken, specify _____

G. Education (circle highest grade completed)

Applicant

School 1 2 3 4 5 6 7 8 9 10 11 12
College 1 2 3 4
Grad School ☐ Yes ☐ No
Professional License ☐ Yes ☐ No
Type _____
Name and address of high school or college
_____
_____

Co-Applicant

School 1 2 3 4 5 6 7 8 9 10 11 12
College 1 2 3 4
Grad School ☐ Yes ☐ No
Professional License ☐ Yes ☐ No
Type _____
Name and address of high school or college
_____
_____

H. Applicant's Driver's License

License No. _____
Issuing State _____
Expiration Date _____

Co-Applicant's Driver's License

License No. _____
Issuing State _____
Expiration Date _____

Please provide information regarding any moving violations, including alcohol and drug-related offenses. Indicate any suspension, revocation or occurrence involving harm to human beings or property.

_____
_____
_____
_____
_____

I. Name and age of each person, including the applicant(s), living in the home and relationship to the applicant(s).

Name	Date of Birth	Relationship

J. Attach a physician's statement indicating that the applicant provider(s) is in good health and physically and emotionally capable of providing Family Care services, along with all required testing.

K. Name(s) of Agency(ies), OTHER THAN OMRDD or the SPONSORING AGENCY, from which individual(s) will be or have moved into the home.

_____
_____

L. Number of years at current address _____ ☐ Own ☐ Rent Lease Expiration Date: _____

Name and Address of owner of residence at which (proposed) family care home is (will be) located, if other than applicant(s).

_____ _____

Name Street

_____

City State Zip Code Phone Number

II. PERSONAL REFERENCE/INFORMATION

A. Name and Address of 3 people NOT related to the applicant(s) who can attest to the applicant(s)' character.

1) _____

Name

_____

Street City Zip Code

2) _____

Name

_____

Street City Zip Code

3) _____

Name

_____

Street City Zip Code

B. Do you have any financial interest in any other agency subject to certification by OMRDD, such as community residence, IRA, ICF/DD, Family Care, or any day services; or building(s) occupied by such a program? ☐ Yes ☐ No If Yes, please describe _____

_____

_____

C. Have you or any member of your household been approved, denied, licensed, or certified under present or any other names by any state, county, or private agency to provide services in the home? ☐ Yes ☐ No

If Yes, please describe ☐ Approved ☐ Denied ☐ Licensed ☐ Certified

_____

_____

_____

D. Have you or any member of your household ever been convicted of a crime (misdemeanor or felony)?

If Yes, please provide name and information on the crime, including date of conviction and court of jurisdiction. You may also supply information about your/their good conduct and rehabilitation.

Applicant ☐ Yes ☐ No

Co-Applicant ☐ Yes ☐ No ☐ No co-applicant

Household Member ☐ Yes ☐ No ☐ No household member(s)

Household Member ☐ Yes ☐ No

_____

_____

_____

_____

E. Are you or any member of your household currently the subject of any pending criminal charges? If Yes, please provide name, information on the crime, and date of charge.

Applicant ☐ Yes ☐ No

Co-Applicant ☐ Yes ☐ No ☐ No co-applicant

Household Member ☐ Yes ☐ No ☐ No household member(s)

Household Member ☐ Yes ☐ No

_____

_____

_____

_____

F. Have you or any member of your household been the subject of an indicated case of child abuse or maltreatment? If Yes, please provide information on the child abuse or maltreatment and date.

Applicant ☐ Yes ☐ No

Co-Applicant ☐ Yes ☐ No ☐ No co-applicant

Household Member ☐ Yes ☐ No ☐ No household member(s)

Household Member ☐ Yes ☐ No

_____

_____

_____

_____

G. Why do you want to become a Family Care Provider? _____

_____

_____

_____

_____

_____

_____

H. What life experiences do you have with individuals with developmental disabilities?

_____

_____

_____

_____

_____

_____

_____

I. Describe any hobbies and interests that you and/or family members have.

J. In what types of activities, both in your home and in the community, do you currently participate?

K. How did you hear about the Family Care Program? Please be specific.

III. CERTIFICATION/RECERTIFICATION

I hereby request an Operating Certificate in accordance with Article 16 of the Mental Hygiene Law be issued in my/our name(s).

For purposes of initial certification or, if certified, I understand that this Family Care home is subject to inspection by the Commissioner of OMRDD or his or her authorized representative(s) at any time, with or without notice.

If an Operating Certificate is granted, I agree:

1. To maintain the Family Care home at the certified address, with the understanding that the certification applies ONLY to this address.
2. To guarantee and protect the civil rights of all individuals in my home.
3. To not exceed the certified capacity.
4. To make all reports as required by the Commissioner.
5. To notify in writing and obtain approval of the Commissioner 60 days prior to voluntarily terminating operation of the Family Care home.
6. To notify in writing and include reason(s) for wanting the individual(s) removed from the home.
7. To notify the sponsoring agency if the individual(s) poses a threat to himself or herself or others.
8. To operate the Family Care home in accordance with all applicable laws, regulations, and policies.
9. To notify sponsoring agency prior to making any renovations or environmental modifications to the Family Care home.
10. To notify sponsoring agency of any prospective household members who intend to move into the home including family members, boarders, and/or individuals placed by other agencies.
11. To provide Family Care services in such a manner as to assure that I will not discriminate against an individual because of his or her race, color, gender, sexual orientation, military status, creed, religion, age, disability, or national origin.
12. To notify the sponsoring agency of any legal involvement, actions or proceedings concerning or affecting any member of the household. This requirement covers, but is not limited to, any arrests, criminal investigations, criminal convictions, restraining orders, orders of protection, income executions, lawsuits, separation agreements, and divorce proceedings involving or affecting any member of the household, and any calls made to the police, or visits made to the home by the police or other law enforcement officials. If I have requested a criminal history record check, I have read and signed the attached disclosure statement.
13. To obtain approval for scheduled absences from the Family Care home (i.e., vacations).

I certify that all information included in this application is accurate and true to the best of my knowledge and understand that any untrue statement, knowingly given, is grounds for revocation, non-renewal or disapproval.

Signature	Print Name	Date
Signature	Print Name	Date

IV. VERIFICATION UNDER OATH

STATE OF NEW YORK COUNTY OF

_____ AND _____

Being duly sworn, deposes, and says that he or she or they is/are the person(s) who has/have executed the above application that the statements in the forgoing application are true of his or her or their own knowledge.

Sworn to before me this _____ day of _____

_____ _____

Notary Public Applicant/Provider Signature

_____

Co-Applicant/Co-Provider Signature

V. SUMMARY (For Sponsoring Agency Use Only)

A. Recommendation(s)

_____

_____

_____

_____

_____

B. Other Comments

_____

_____

_____

_____

_____

C. Certified Capacity Excluding Respite/Tubs _____ Respite/Tubs Capacity _____ Total Capacity _____

Print Name of Person Reviewing the Form _____

Print Title of Person Reviewing the Form _____

Signature _____ Date Reviewed _____

Approved by _____ Title _____ Date of Approval _____

Date of Disapproval _____ Further Action Required ☐ Yes ☐ No

Comments

_____

_____

_____

_____

_____

Form OMR 106 (MR)(12/05)

Request for Criminal History Record Check

NYS Office of Mental Retardation and Developmental Disabilities
Criminal Background Check Unit
PO Box 3005
Schenectady, NY 12303-0005
cbc.unit@omr.state.ny.us

This form is to be used only by voluntary agencies and DDSOs. The purpose of this form is to formally request a criminal history record check. For state employees, DDSO should use Form OMR 106S.

Instructions:

1. Complete all fields on the form. Please print legibly.
2. Authorized party must sign and date the form.
3. If Livescan prints are being taken, give completed form to applicant to bring to Livescan location.
4. If "ink and roll" is being used, mail the completed form along with fingerprint cards and Form OMR 107 to the CBC Unit at above address.

Agency/DDSO Name	Agency Corp ID

Applicant's Last Name	First Name	MI

Date of Birth	Social Security Number

Street Address or PO Box (applicant's)

City	State	Zip

Status (check one)	Position Type (check one)	Program Type (four digit code select from page 2)
☐ E – Employee (non state)	☐ Support	___ ___ ___ ___
☐ V – Volunteer	☐ Administrative	
☐ F – Family Care Provider	☐ Clinical	
☐ A – Adult household member	☐ Direct Care	
☐ R – Family Care Respite/substitute	☐ Not Applicable	
☐ H – Adult household member		
☐ N – Employees of vendors and contractors		

The applicant will have regular and substantial unsupervised or unrestricted physical contact with individuals receiving services and is a subject party concerning whom a criminal history record check is required by law. The results of the criminal history record check will be used solely for purposes authorized by law. Informed consent has been given by the applicant and is on file.

Please check if applicable:

☐ This is an expedited request (see CBC Policy 101.3 for expedited criteria).
☐ A request for a criminal history record check has been submitted to OMH on or after April 1, 2005.

Name of Authorized Party _____

OMRDD Secure Message ID _____

Signature of Authorized Party _____ Date _____

December 2000	FAMILY CARE PHYSICIAN'S APPROVAL FORM	Policy 10.3.1.B

MUST BE ON SPONSORING AGENCY LETTERHEAD

Date _____

Dear _____

I/we, _____ hereby authorize and consent to the
(Applicant/Provider)

release of confidential information by _____
(Physician's Name)

_____ ( ) _____
Address Telephone Number

to the _____ Developmental Disabilities Services Office or

Sponsoring Agency.

Signature _____
Provider (s)

Address _____

Zip Code _____ Telephone ( ) _____ Date _____

Form: OMR-10.3.1B (I)

MUST BE ON SPONSORING AGENCY LETTERHEAD

Dear _____:

Please complete the following and return in the enclosed stamped addressed envelope.

Provider (s) Name: _____

Date of last visit or physical examination: _____ result of last PPD Mantoux Skin Test _____. If there is a prior documented significant reaction to Mantoux Skin Testing or another contraindication to Mantoux Testing, please attach a statement indicating that, in your opinion the individual is free of active Tuberculosis (TB). Date of last Hepatitis B Testing.

1. Are immunization(s) up to date? _____

2. Is the applicant/provider currently under your care for any medical condition? If so, for what?

3. Does the applicant/provider have any serious medical condition or physical limitations, e.g., lifting or other limitations, e.g., emotional, mental condition that should be taken into consideration for providing family care?

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. Are there any concerns with applicant's/provider's ability to provide a home and care for an individual with a developmental disability?

_____

_____

_____

_____

_____

_____

_____

_____

5. Other Comments:

_____

_____

_____

_____

_____

Signature of Physician: _____ Date: _____

MUST BE ON SPONSORING AGENCY LETTERHEAD

Date:

Dear _____

Please complete the following and return in the enclosed stamped addressed envelope.

Name: _____ Date of Birth: _____ SS# _____

Mailing Address: _____ Home Phone: ( ) _____

Primary Care Physician: _____ MD's Phone: ( ) _____

Mailing Address: _____ Zip Code _____

Sex: M ( ) F ( ) Height ( ) Weight ( )

Date of last visit or physical examination: _____ Result of last PPD Mantoux Skin Test _____

If there is a prior documented significant reaction to Mantoux Skin Testing or another contraindication to Mantoux Testing, please attach a statement indicating that, in your opinion the individual is free of active Tuberculosis (TB). Please indicate last Hepatitis B Testing.

I. GENERAL MEDICAL HISTORY

a. How do you consider your health (e.g., : excellent, very good, good, fair, poor) _____

b. Has there been ANY changes in your general health in the past year? (If yes, explain) _____

_____

c. Are you PRESENTLY under a doctor's care? ____ If yes, for what reason? _____

A. Within the last year, have you had or been diagnosed with any of the following:

	YES	NO	EXPLAIN
Chest Pain			
Heart Attack			
Damaged heart valve(s)			
Shortness of breath after mild exercise			
Blood pressure problems			
A heart pacemaker			
Blood clot(s)			
Fainting spells			
Seizures (convulsions)			

	YES	NO	
Dizzy Spells			
Frequent headaches			
Migraine headaches			
Emphysema			
Asthma			
Chronic Bronchitis			
Tuberculosis			
Stomach ulcer			
Hepatitis			
Diabetes			
Hypothyroidism			
Hyperthyroidism			
Arthritis			
Rheumatism			
Osteoporosis			
Herniated disc			
Frequent back pain			
Cancer			

B. Within the last year, have you had or have you been diagnosed with any disease, condition or problem NOT listed above that you think we should know about? If yes, please explain: _____

C. Do you wear glasses? _____ Contact Lenses? _____

D. Have you been told that you have glaucoma? _____ If yes, when? _____

II. ALLERGIES

a. Have you had a reaction to any drugs or medicines in the last year (e.g., : aspirin, penicillin, sulfa drugs, etc.) _____

If yes, which ones? _____

b. In the last year, have you been diagnosed as allergic to bee stings? _____ If yes, do you use/carry an epipen? _____

c. In the last year have you had hives or a skin rash? _____

d. Other allergies, please specify _____

MEDICATIONS

Please list any medications that you are currently taking:

To the best of my knowledge, the information provided in this form is accurate.

Print Name Signature Date

SAMPLE LETTER
MUST BE ON SPONSORING AGENCY LETTERHEAD

Dear

Your employee _____, and his or her family have made application to provide services to individuals who are developmentally disabled.

Please assist us in evaluating this family by completing the attached form, and returning it in the enclosed envelope. This information will be held in confidence.

Your prompt attention and assistance is greatly appreciated.

Sincerely,

EMPLOYMENT REFERENCE

1. Present employment status _____

2. How long has Mr. or Mrs. or Ms. _____ been employed with your agency or organization and in what capacity? _____

3. Has Mr. or Mrs. or Ms. _____ attendance been satisfactory? Please explain. _____

4. Is Mr. or Mrs. or Ms. _____ reliable? Please explain. _____

5. Does Mr. or Mrs. or Ms. _____ work well with co-workers and supervisors? Please explain. _____

Please add any additional comments that will assist us in evaluating this family.

SAMPLE LETTER
MUST BE ON SPONSORING AGENCY LETTERHEAD

Dear

Your name has been given to us as a reference by _____ who has made application to provide services for individuals with developmental disabilities as part of OMRDDs Family Care Program.

Please provide us with information to evaluate this family by completing the attached form and returning it in the enclosed envelope.

Your prompt attention in this matter is greatly appreciated.

Sincerely,

FAMILY CARE REFERENCE

RE: _____
_____
_____

1. How long have you known the applicant and his or her family and in what capacity?

_____
_____
_____
_____
_____

2. Based on your experience and knowledge of the applicant and his or her family, do you feel that they would be able to provide care for a child or an adult who is developmentally disabled and/or physically or emotionally handicapped? Please explain.

_____
_____
_____
_____
_____

3. Based on your experience and knowledge of the applicant and his or her family, do you feel that they would be able to relate to others of different race, religion or national origin?

_____
_____
_____
_____
_____

4. Based on your experience and knowledge of the applicant and his or her family, do you feel that this family can provide positive and stable home environment to an individual placed in their home? _____
_____
_____
_____
_____
_____
_____

5. Based on your knowledge and experience of the applicant and his or her family do you feel that this family is capable of coping with the extra challenges that an individual with a developmental disability can bring to a home and family?. _____

_____
_____
_____
_____
_____
_____
_____
_____

6. Please add any additional information or personal comments that will assist us in evaluating this person or family as a perspective family care provider(s). _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your prompt attention and assistance in this matter. If you have any questions please contact me at _____.

Signature _____ Date _____

Address _____

SAMPLE LETTER
MUST BE ON SPONSORING AGENCY LETTERHEAD
(Optional)

The parent/guardian of one of your student's, _____ has made application to provide care, and services to individuals who are developmentally disabled.

Please assist us in evaluating this family by completing the attached form and returning it to us in the enclosed envelope. This information will be held in confidence.

Thank you for your prompt attention and assistance in this matter.

Sincerely,

SCHOOL REFERENCE
(Optional)

RE: _____ **STUDENT:** _____

1. Are the parents involved in school activities or organizations? _____

2. Additional comments: _____

FAMILY CARE
CHILD ABUSE PREVENTION ACT
REQUIREMENTS FOR BACKGROUND CHECKS
OF APPLICANTS/REAPPLICANTS/AND OTHER
ADULTS RESIDING IN THE HOME

December 2000 **Policy 10.3.1F**

It is the responsibility of OMRDD and its DDSOs to provide, to the extent possible, for the safety and protection of people receiving services. In accordance with New York State Department of Social Services Law, Article 6, Section 424-a, OMRDD will conduct a background check on prospective Family Care providers, and any other adult residing in the home to determine if anyone has ever been the subject of an indicated child abuse or maltreatment report.

Although all Family Care providers will not serve children, OMRDD has interpreted this law to allow the submission of all Family Care applicants since they may, at sometime, provide services to children. Therefore, all Family Care provider applicants, reapplicants and other adults residing in the home will have a background check conducted by the State Central Register at the time of application and reapplication as a condition of consideration for certification.

The law also requires that notification be made to any party for whom background checks are required that an inquiry can, and will be made to the New York State Office of Children and Family Services as to whether the party has been the subject of an indicated child abuse, and maltreatment report. The applicant or provider must acknowledge in writing that this information has been given to them. To do a background check, form DSS-3370 (see attached form), will be completed by the provider, and the DDSO will submit it to the New York State Office of Children and Family Services.

If a Family Care applicant/reapplicant, or an adult residing in the home of an applicant or provider is found to be the subject of an indicated report, the State Central Register will forward notice of this finding to the subject at his or her home address, as well as to the DDSO. If the notification indicates that someone is the subject of a report, the DDSO can only obtain the fact of the case if the applicant or provider completes an "*authorization for release of report.*" Failure, on the part of an applicant/reapplicant, to provide the authorization will result in denial of the original application for an operating certificate or non renewal of the present operating certificate

ACKNOWLEDGMENT BY APPLICANT/REAPPLICANT OF THE PROCESS WHEREBY THE APPLICANT'S HISTORY IN RELATION TO POSSIBLE CHILD ABUSE OR MALTREATMENT IS SCREENED AT THE STATE CENTRAL REGISTER

I, _____,
(Name of applicant - type or print)

_____ have
_____ have not

been a subject of an indicated report of child abuse or maltreatment. (An **indicated report of child abuse** is a report on file with the State Central Register of the New York State Office of Children and Family Services because some credible evidence exists to support that you have been involved in a case of child abuse and/or maltreatment.)

I have received notice of the requirements of Social Services Law 424-a, and I understand that if information regarding my past history with the State Central Register for Child Abuse and Maltreatment is contained in a report from the Register, it will be used to determine my suitability to be a Family Care Provider. I further understand that any misrepresentation of my status or of the information given will result in administrative action, which may include revocation or suspension.

--- ---
(Applicant's Signature) (Date)

NOTE: all applicants who have the potential for regular and substantial contact with children cared for by the provider agency should complete a form such as this. It would be used to record the fact that an applicant has been informed that a background check will be made for potential indicated cases of child abuse or maltreatment. The Child Abuse Prevention Act requires that such notification be made.

NOTE: This information is to be given to all applicants and reapplicants for Family Care certification.

NOTICE OF SOCIAL SERVICE LAW 424-a PROCEDURES

(Relative to a background check to determine if an applicant is the subject of an indicated report of child abuse or maltreatment on file with the State Central Register of Child Abuse and Maltreatment)

Please read this carefully.
It may impact upon your provision of services
with OMRDD.

Section 424-a of the New York State Social Services Law requires this agency, as a provider of services for children in Family Care homes operated or certified by the Office of Mental Retardation and Developmental Disabilities (OMRDD), to inquire whether anyone actively being considered for certification as a Family Care provider or any adult residing in the home who has potential or regular and substantial contact with children being cared for by the agency is the subject of an indicated report of child abuse or maltreatment on file with the State Central Register of Child Abuse and Maltreatment (New York State Office of Children and Family Services).

This DDSO will make the required inquiry to the State Central Register regarding yourself, based on your application to become a Family Care provider. If the result of this inquiry shows that you or any adult residing in your home is the subject of an indicated report of child abuse or maltreatment, the State Central Register will notify you of this. This DDSO will also be advised of the findings.

If the State Central Register replies that you or any adult residing in your home is the subject of an indicated report of child abuse or maltreatment, this DDSO must consider that factor, long with other background information, in determining whether to certify you as a Family Care provider. You may be asked to provide details of the situation (s) that gave rise to the indicated report. You will also be asked to sign a release allowing this agency to receive a copy of the indicated report on file with the State Central Register. Your refusal to sign this release will be taken to mean that you do not wish to further consider your application or continue to provide services as a Family Care provider.

If you are denied certification as a Family Care provider - - and such denial is based, in whole or in part, on the existence of an indicated report of child abuse or maltreatment, you will be provided a written statement explaining the reason for the denial. You will be informed, at that time, of your right, pursuant to Section 22 and 424-a of the Social Services Law, to request a hearing before the New York State Office of Children and Family Services on the indicated report on file with the State Central Register. All information obtained through this process is confidential.

Given to: _____ By: _____
(Applicant-type or print) (Name of agency employee - type or print)

_____
(Signature of agency employee)

For: _____
(Agency Name)

Date: _____

AUTHORIZATION FOR RELEASE OF REPORT
FROM THE
STATE CENTRAL REGISTER ON CHILD ABUSE AND MALTREATMENT

(To be prepared by the provider agency on agency letterhead)

New York State Central Register
40 North Pearl Street
Albany, New York 12243

(Name of indicated applicant) was recently identified by the State Central Register as a subject of an indicated report of child abuse and/or maltreatment, in accordance with the provisions of Section 424-a of the Social Services Law.

I, **(Name of DDSO representative),** hereby request the New York State Central Register to furnish this DDSO with the information continued in Report # _____. By the signature below, the subject of this report has authorized release of the contents of this report to me.

_____
(Signature of authorized agency representative)

_____
Title Date

==========

I, **(Name of indicated applicant)** , being the subject of the above request, do hereby authorize the New York State Central Register of Child Abuse and Maltreatment to furnish, to the individual, the contents of the indicated report, _____.

_____ Date _____

STAPLE TO DSS 3370 AS ADDITIONAL PAGE (IF NEEDED)

STATE CENTRAL REGISTER CLEARANCE FORM CONTINUED

APPLICANTS NAME:

Other Household Members are:

SCR USE ONLY	RELATION TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH M	D	Y

Rev. October 2000	FAMILY CARE STATEMENT OF PROHIBITION OF ABUSE AND NEGLECT	Policy 10.3.1G

The Statement of Prohibition of Abuse and Neglect

I, _____, Family Care Provider for DDSO, have read and fully understand the contents in 14 NYCRR Part 624 Reportable Incidents, Serious Reportable Incidents, and Abuse. I further understand that I cannot, and will not, in any manner, cause harm to any individual living in my home. I further understand that I must, within 24 hours, report all incidents, i.e., abuse, neglect, injury, or leave without consent to the local DDSO.

Failure on my part, any member of my household, or respite provider, arranged by me or by the DDSO, to uphold the guidelines in 14 NYCRR Part 624, or OMRDDs policies and procedures, may constitute the suspending or revoking or terminating of my operating certificate.

Signed: _____ Date:

Signed: _____ Date:

Rev. August 2004	FAMILY CARE CRITICAL DRIVER CERTIFICATION PROGRAM	Policy 10.3.1 H

It is the responsibility of OMRDD to ensure that individuals being transported by certified Family Care providers are safe and protected to the fullest extent possible. To this end, OMRDD has mandated the enrollment of each certified Family Care provider who holds a New York State Driver's license in the New York State Department of Motor Vehicles' (DMV) Critical Driver Certification Program. The Critical Driver enrollment process is also applicable to substitute providers who are willing to provide transportation.

For those certified Family Care providers that do not hold a valid New York State Driver's License but do hold a license from another State, it is the responsibility of the DDSO to obtain the following information: the license number, the class of license, the issuing State, and the expiration date.

On at least a semi-annual basis, the DDSO must obtain from the licensing state, an abstract of the provider's license. If the license has been suspended, revoked or has a limitation put on it, steps 8 and 9 must be followed. It is the responsibility of the Family Care provider to notify the Sponsoring agency when their license has been reinstated. The Sponsoring agency must verify this information with the issuing State.

What is the Critical Driver Certification Program (CDCP)?

1. A state operated program that monitors people who have "critical" driving responsibilities.

2. The DMV maintains a Critical Driver file for each DDSO. The database maintains each enrolled driver's class of license, e.g., commercial driver's license endorsement, expiration date, and current status (valid or suspended or revoked).

3. Whenever an enrolled driver has his or her license suspended or revoked DMV produces a Notification Report. The Notification Report is sent to the DDSO administration. When the suspension or revocation action is prompted by a conviction, the conviction information is shown on the Notification Report as well.

4. In some instances, a driver may be eligible to obtain a limited use license that will allow him or her to continue driving for employment purposes. If this is the case, the driver's eligibility for a limited use license is also shown on the Notification Report.

5. The Notification Report is produced weekly, and represents activity that occurred the preceding week. In most cases, the notification will occur in advance of the effective date of the suspension or revocation.

6. All information obtained by the DDSO through DMV Critical Driver Certification Program must be kept confidential.

The DDSO, upon notification of revocation or suspension of a driver's license, ensures that the Family Care provider is removed from driving Family Care individuals, and makes with the provider, necessary alternative arrangements for transportation to programs and services.

Enrollment and Monitoring Procedure:

RESPONSIBILITY	PROCEDURE
Family Care Coordinator	1. Using the Program Directory for Family Care (PR5) available through TABS, compiles a list of certified Family Care providers (first and last name and middle initial, if known). For each certified Family Care provider listed includes: a. a Motorist ID Number if he or she holds a New York State driver's license OR b. a notation that he or she does not have a driver's license. 2. Signs the list. 3. Forwards the list to the DDSO's Critical Driver Certification Program liaison. 4. Notifies the DDSO CDCP liaison to add or delete a name from the enrollment roster when the Family Care home closes, a new home opens or the Family Care provider no longer has a license.

DDSO Critical Driver Liaison	5. Using the DDSO specific Family Care provider code created by the Department of Motor Vehicles (DMV), prepares a diskette separately from that used for DDSO staff. Includes the names and Motorist ID numbers of the Family Care providers who hold New York State driver's licenses on the diskette.
	6. Sends the diskette to DMV in Albany for enrollment processing.
	NOTE: Adds or deletes names upon notification from the Family Care Coordinator or designee.
DDSO Critical Driver Certification Liaison	7. Upon notification from DMV that a driver's license has been suspended or revoked, immediately calls the Family Care Coordinator or designee. Sends a copy of the DMV Notification report to the Family Care Coordinator or designee.
Family Care Coordinator or Designee	8. Upon notification of a driver's license suspension and/or revocation, immediately instructs the Family Care provider that she or he must <u>not</u> drive the Family Care individual.
	9. Makes necessary alternative arrangements with the Family Care provider for all transportation the Family Care individual requires including day program, recreation/community inclusion activities, and medical appointments.
DDSO Critical Driver Liaison	10. Notifies Family Care Coordinator or designee when a driver's license has been reinstated.

June 1998	FAMILY CARE EMPLOYEES AS PROVIDERS	Policy 10.3.2

State employees may be certified as Family Care providers when it is in the best interest of a particular individual to consider movement into the home of an employee. The employee will not receive preferential treatment, and as with any Family Care provider, must participate in the development of the individual's individualized service plan. All requirements for certification apply to the employee requesting to be a Family Care provider.

The employee's actions in either role, employee or provider, will impact on the continuation of the operating certificate. Notification by DDSO is required along with a statement acknowledging such by the employee. Please see attached form.

0FF-DUTY CONDUCT BY EMPLOYEES CERTIFIED AS FAMILY CARE PROVIDERS

As a Family Care Provider who is also an employee of New York State, I am aware that I am responsible for maintaining a satisfactory working relationship in each setting, and assuring that my conduct in either setting will not call into question my competency in the other.

Decisions regarding the continuation of my Operating Certificate, or my status as an employee can be influenced by my actions in either role. I understand that I have a contractual right to representation by the union or by an attorney that I hire at every stage of the disciplinary process under my collective bargaining agreement. My right to such representation includes investigations of incidents or events that occur when I am functioning as a provider of Family Care services and I become the likely or potential target or subject for disciplinary action as an employee of the local DDSO.

Signature of Employee: _____ Date

c. DDSO Personnel Office
DDSO Family Care Coordinator

December 2000	FAMILY CARE HOMES USED BY MORE THAN ONE STATE AGENCY –AGREEMENT FORM	Policy 10.3.3

Family Care homes may be certified by more than one State Agency. Any such intermingling of individuals with developmental disabilities, and others in a home is subject to the approval of the DDSO director. There must be prior written agreement between the DDSO director, and the director of the other placing state or voluntary agencies before individuals with developmental disabilities can be intermingled with others in any home.

The DDSO director is responsible for developing written agreements with directors of other state agencies to clarify:

1. Responsibilities of each agency.

2. Resources, financial as well as staffing, must be provided by each agency.

3. Regulations and restrictions of each agency.

4. Procedures for resolving conflicts between agencies.

5. Conditions for moving an individual in the home; and

6. Conditions for removal of an individual with developmental disabilities or others from a home.

Family Care homes may not have a dual certification with the Office of Children and Family Services homes known as Family Type Home For Adults (FTHA) according to the Department of Social Services Law. These homes serve from one to four individuals in need of personal assistance and/or supervision.

To better serve individuals who are in need of, the _____ DSO and the _____may share Family Care homes which are certified by the local DDSO and approved by the _____in accordance with its own guidelines and regulations. The purpose of this agreement is to establish guidelines for coordinating mutual responsibilities for services to providers and individuals living in these homes.

We, the undersigned, mutually agree to the certification and the use of the home of _____, located at _____as a shared family setting for a maximum number of unrelated people not to exceed a capacity of _____.

To facilitate communication between both agencies, and in keeping with professional standards of confidentiality, each shared home provider must sign a consent to release information between the local DDSO and the_____ agency.

1). **Responsibilities of Each Agency:**

a). The _____must recertify the homes at least every three years and will conduct reevaluation of the home annually. When an individual with a disability is placed, a home liaison must supervise the home and visit at least once a month, or as determined by the local DDSO.

b). The individuals placed by _____will also be supervised by the agency staff unless an individual written plan of care has been jointly prepared in which there is a sharing of this responsibility for a particular individual. In such cases, the specific areas of responsibility will be defined.

c). The investigation of any incident, including allegations of abuse, will be conducted by the agency with responsibility for the person in whose behalf the incident\allegation has been made. Circumstances may demand dual investigations when individuals placed by both agencies are affected by the incident or the alleged victim in an allegation of abuse. The two agencies will inform each other of the involvement of other agencies (e.g., police department, Child or Adult Protective Services) and investigation findings and outcomes as soon as possible.

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

_____ {DATE}_____

{applicant's name and address}

_____
_____
_____

Dear _____{applicant} _____:

It is the decision of the Office of Mental Retardation and Developmental Disabilities, pursuant to Section 16.05 of the Mental Hygiene Law, to deny your application for renewal of the operating certificate to operate a Family Care home at the above address. This decision is being taken after a careful review of your application by this office.

This action is based in part, but not limited to, the following finding(s):

_____
_____
_____

in violation of regulations at 14 NYCRR _____. As a Family Care provider, you are responsible for insuring that all applicable regulations and laws are fully compiled with in the operation and management of the Family Care home.

You have the right to an administrative hearing to appeal this denial of your application for an operating certificate. You also have the right to be represented by an attorney at such a hearing. In order to have such a hearing, you must request in writing, within 30 days of your receipt of this letter, to:

Paul R. Kietzman, Esq.
General Counsel
New York State Office of Mental Retardation
And Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

Your written request for a hearing must include a copy of this letter. You should also submit a copy of your request to me.

If you decide not to request a hearing, your operating certificate will effectively expire 30 days from your receipt of this letter.

Sincerely,

Director

cc. Office of Counsel

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

_____ {DATE) _____

{provider's name and address)

_____
_____
_____

Dear _____{provider}_____

On _____ your operating certificate, No. _____,
To operate a Family Care home at the above address expired. Please return the operating certificate to:

_____
_____
_____
_____

Sincerely,

Director

Rev. 4/98
CALP-102

An increase in the capacity of Family Care homes which results in a certified capacity of more than four (4) individuals requires the support of the DDSO Director and the approval of the associate commissioner or his or her designee.

A Family Care provider who requests an increase in certified capacity for more than four individuals must complete Form 240B *Request to Increase Certified Capacity*. The form must be submitted to the Family Care Coordinator or his or her designee for review and completion. If the Family Care Coordinator or his or her designee supports the requests to increase the certification of the home, they must complete Form 240B and provide a clinical evaluation of the family and home along with supporting documentation for the director's review. If the DDSO Director supports the requests, the Director submits the signed form with supporting documentation to the Associate Commissioner (or his or her designee) for a determination.

REQUEST TO INCREASE CERTIFIED CAPACITY

When a change in certified capacity is requested, the provider must complete the following form and submit it to the Family Care Coordinator or his or her designee for review and completion. The form must be reviewed by the DDSO Director and forwarded to the Associate Commissioner (or his or her designee) for a determination.

( ) Current Certified Capacity ( ) Requested Certified Capacity

I, _____ , Family Care Provider residing at _____ request an increase in the certified capacity of my home based on _____

_____

_____

_____

Signature _____ \ _____ Date _____
Family Care Provider(s)

==========

I, _____, Family Care Coordinator recommend ( ) or deny ( ) that this home be increased from ____ to ____ based on the following reason(s)_____

_____

_____

_____

Signature _____ Date

==========

I,_____, Director of _____, recommend ( ) or deny ( ) the request for increased capacity based on _____

_____

_____

Signature DDSO Director _____ Date_____

==========

I, _____, Associate Commissioner or designee, approve ( ) or deny ( ) Mr, Mrs, Ms, M/M _____ request for increased capacity based on _____

_____

_____

Signature Associate Commissioner or Designee _____ Date _____

==========

Form 240B Rev. 9/03

cc: Family Care Provider's File
Family Care Coordinator
Director or Designee

(8/18/03)

FAMILY CARE HOME REGISTRATION FORM

10.3.5

I. PROGRAM INFORMATION

Action: (Check appropriate box)*

OPERATING CERTIFICATE # _____ NEW PROGRAM ___ OTHER___**

Program Type (Check One) SSFC ___ ASFC ___ County _____

OSC/AGENCY Code and Name _____

Provider(s) Last Name, First Name MI

Name _____ SS#. _____ - _____- _____

Name _____ SS#. _____ - _____-_____

Telephone (___ ___) _____- _____ _____

Provider Address Information:

Address _____

City: _____ State _____ Zip Code _____

Mailing Address (if different from above)

Address: _____

City: _____ _____ ___ State _____ Zip Code _____

DDSO USE ONLY

Certified Capacity: _____ Respite Beds: _____ Census ___ Boarders ___

II TRANSACTION INFORMATION (Enter Dates)

DDSO USE ONLY

Certification Effective Date ____/____/____ Expiration Date ____/____/____ **Issue Date:** ___/___/___

* * Change in provider information: / _ / Other

_____

Comments: _____

_____

Completed by: Staff Name: _____ Date: ___/____/ ___ Phone (___) _____

E-Mail to: COOPCERT Subject: FC - (Name of Home) Entered into TABS: ___/___/___ **Initials:** _____

_____

** Note: Demographic changes, Program name changes, Recertifications, Closings are entered by the DDSO staff. **DO NOT SEND THESE REQUESTS TO COOPCERT.** See TABS Help for SY19, SY21, SY22, and SY23 for more information. (Path: Central Office NEWS/TABS Information/TABS On-line Help/TABS Specific Option Help/System Management/PROGRAM NAME CHANGE or /FAMILY CARE ADDRESS UPDTE or /FAMILY CARE CERTIFICATION UPDATE or /FAMILY CARE CLOSE PROGRAM.

June 1998	FAMILY CARE ADEQUACY OF RESOURCES	Policy 10.3.6

New York State Codes Rules and Regulations (NYCRR) Title 14 Section 687.4 (b) (5) (iii) states "*No operating certificate will be issued by the Commissioner unless there is satisfaction as to: . . . the adequacy of financial resources of the applicant and the stability of sources of future revenues . . .*"

OMRDD's primary concern has been, and continues to be the health, and welfare of individuals with mental retardation and developmental disabilities. It is OMRDD's statutory responsibility to provide for the safety, and well being of these individuals, as well as, provide administrative oversight to the programs which serve them.

Family Care is unique and requires an approach to quality assurance that is unlike any other certified program. The combination of a privately-owned home, and service provision by a family rather than by a not-for-profit voluntary agency, has over the years led to a regulatory and policy base which must recognize the strengths, weaknesses, and inconsistencies of family living. The regulations which establish the grounds for issuing an operating certificate were written as a means to assure a safe, orderly, family environment for individuals with disabilities.

One of the most basic requisites for any applicant seeking to be certified as a Family Care provider is home ownership (rental or lease). The continued maintenance of a home, which meets the physical plant requirements, as established in the regulations, is the most primary of any Family Care standard. Individuals are placed in Family Care homes usually with the intent of long-term placement, and integration into the lives of the provider, and their families. If a Family Care applicant is not able to demonstrate their ability to meet the day-to-day expenses of their home, and family, the impact on individuals with disabilities living in the home may be significant.

At the time of certification, providers need to prove to the satisfaction of the commissioner, their ability to care for themselves, and their home, without the anticipated money of a prospective Family Care individual. *FAMILY CARE PAYMENT IS NOT GUARANTEED.* Individuals move from homes for reasons that are sometimes outside the control of the provider resulting in a reduction in reimbursement levels. If the provider does not have sufficient financial resources to continue to meet the expenses associated with the home (mortgage, utilities, etc.) the well being of the other individuals in the home may be in jeopardy.

There is no *"magic number,"* threshold or savings account balance OMRDD can use to establish a statewide standard. Each family situation must be carefully considered, and assessed to make an informed decision. Each DDSO may offer assistance in the area of financial management, and budgeting through training programs to include workshops, seminars, as well as, assist providers to understand their reimbursements, and the likelihood that their payments may fluctuate.

The money generated by the Family Care Program is essential to Family Care providers, and OMRDD staff must recognize the importance of this funding in providing a comfortable environment for all individuals living in the home. An accurate and timely Family Care payment will help to ensure the availability of sufficient resources to support Family Care individuals.

SECTION 10.4

MONITORING OF CERTIFIED FAMILY CARE HOMES

10.4.1 Inspection and Investigation

10.4.1A Form 238 Family Care Home Evaluation and Survey

10.4.2 Visitation

10.4.2A Form 239 Family Care Monthly Checklist

10.4.3 Visitation Plan

10.4.3A Visitation Schedule

10.4.4 Approval\Reapproval Substitute Providers

10.4.5 OMR - Form 236R ADM Substitute Provider Home Survey For One-and-Two Family Dwellings

10.4.6 OMR - Form 236 RP ADM Substitute Provider Home Survey For Multiple Dwellings

10.4.7 Scheduled Absences

Family Care
Re-Affirmation Statement for Recertification

I hereby request an Operating Certificate in accordance with Article 16 of the Mental Hygiene Law be issued in my/our name(s).

For purposes of Recertification, I understand that this Family Care home is subject to inspection by the Commissioner of the Office of Mental Retardation and Developmental Disabilities (OMRDD) or his or her authorized representative(s) at any time, with or without notice.

I hereby declare that I have sufficient resources to maintain my family and household.

If an Operating Certificate is granted, I agree to:

1. Maintain the Family Care home at the certified address, with the understanding that the recertification applies ONLY to this address.

2. Guarantee and protect the civil rights of all individuals in my home.

3. Not exceed the certified capacity.

4. Make all reports as required by the Commissioner of OMRDD or his or her authorized representative(s).

5. Notify in writing and obtain approval of the Commissioner or his or her representative(s) sixty (60) days prior to voluntarily terminating operation of the Family Care home.

6. Notify in writing and include reason(s) for requesting that an individual(s) be removed from the home.

7. Immediately notify the sponsoring agency if the individual(s) poses a threat to him or herself or others.

8. Operate the Family Care home in accordance with all applicable law(s), regulation(s), and policy(ies).

9. Notify sponsoring agency Family Care staff prior to making any environmental modifications or renovations to the Family Care home.

10. Notify the sponsoring agency of any prospective household members who intend to move into the home, including: family members, boarders and/or individuals placed by other agencies.

11. Provide Family Care services in such a manner as to assure that I will not discriminate against an individual in terms of his or her race, color, gender, sexual orientation, military status, creed, religion, age, disability or national origin.

12. Notify the sponsoring agency of any legal involvement, actions or proceedings concerning or affecting any member of the household. This requirement covers, but is not limited to, any arrests, criminal investigations, criminal convictions, restraining orders, orders of protection, income executions, lawsuits, separation agreements, and divorce proceedings involving or affecting any member of the household, and any calls made to the police, or visits made to the home by the police or other law enforcement officials.

13. To obtain approval for scheduled absences from the Family Care home (i.e., vacations).

I have read and signed the attached disclosure statement. *(If requesting a criminal history record check)*

Please attach additional sheet if needed for information requested under A, B, C, D or E.

A. Do you have any financial interest in any other agency subject to certification by OMRDD, such as community residence, Family Care, IRA, ICF/DD, or any day services or building(s) occupied by such a program? ( ) Yes ( ) No If Yes, please explain.

_____

_____

_____

B. Have you or any member of your household been approved, denied, licensed, or certified under present or any other names by any state, county, or private agency to provide services in the home? ☐ Yes ☐ No

If Yes, please describe ☐ Approved ☐ Denied ☐ Licensed ☐ Certified

_____

_____

_____

C. Have you or any member of your household ever been convicted of a crime (misdemeanor or felony)? If Yes, please provide name and information on the crime, including date of conviction and court of jurisdiction. You may also supply information about your/their good conduct and rehabilitation.

Applicant	☐ Yes	☐ No	
Co-Applicant	☐ Yes	☐ No	☐ No co-applicant
Household Member	☐ Yes	☐ No	☐ No household member(s)
Household Member	☐ Yes	☐ No	

_____

_____

_____

D. Are you or any member of your household currently the subject of any pending criminal charges? If Yes, please provide name, information on the crime, and date of charge.

Applicant	☐ Yes	☐ No	
Co-Applicant	☐ Yes	☐ No	☐ No co-applicant
Household Member	☐ Yes	☐ No	☐ No household member(s)
Household Member	☐ Yes	☐ No	

_____

_____

_____

E. Have you or any member of your household been the subject of an indicated case of child abuse or maltreatment? If Yes, please provide information on the child abuse or maltreatment and date.

Applicant	☐ Yes	☐ No	
Co-Applicant	☐ Yes	☐ No	☐ No co-applicant
Household Member	☐ Yes	☐ No	☐ No household member(s)
Household Member	☐ Yes	☐ No	

_____

_____

_____

I, _____, residing at _____,
Certify that all information included in this application is accurate and true to the best of my knowledge.
I understand that any untrue statement, knowingly given, is grounds for revocation or non-renewal.

_____

Signature Print Name Date

_____

Signature Print Name Date

Family Care
Re-Affirmation Statement for Recertification

SUMMARY (OMRDD/Sponsoring Agency Use Only)

A. Recommendation(s)

_____
_____
_____
_____
_____

B. Other Comments

_____
_____
_____
_____
_____

C. Certified Capacity Excluding Respite/Tubs _____ Respite/Tubs Capacity _____ Total Capacity _____

Print Name of Person Reviewing the Form _____

Print Title of Person Reviewing the Form _____

Signature _____ Date Reviewed _____

Approved by _____ Title _____ Date of Approval_____

Date of Disapproval _____ Further Action Required ☐ Yes ☐ No

Comments

_____
_____
_____
_____
_____

2). Resources Provided by Each Agency:

Each agency must assure, through a written agreement, that room and board expenses, clothing allowances, medical coverage and transportation expenses for each individual placed by that agency are provided in accordance with established agency benefit programs. Other support services and assistance must be provided as determined by the needs of the individual and in accordance with each agency's regulations, policies, procedures, and available resources.

3). Regulations and Restrictions of each Agency:

a). Shared homes must comply with certification requirements of the New York State Office of Mental Retardation and Developmental Disabilities. The _____DDSO must be responsible for recertification of the home at least every three years according to 14 NYCRR Section 635-7.4 and 14 NYCRR Part 687 Governing Family Care Home Certification.

b). Shared homes must comply with certification requirements of _____. The agency must be responsible for maintaining the home in accordance with regulations governing its foster care or Program.

c). Shared homes must assure that the individuals served who are sharing bedrooms facilities are of the same sex and age group, except in the case of infants and very young children (three years of age and under) or spouses.

d). Planned conferences between the agencies are to be scheduled at least annually to review the current status of the home.

4). Procedures for Resolving Conflicts Between Agencies:

A conference must be held between the designated liaison staff of each agency. If the conflict cannot be resolved at this level, then a conference must be held by involving the director or his or her designee from both agencies.

5). Conditions for Placement:

a). Regular - Before any individual is presented to the family for consideration, the placing agency must consult with the designated representative of the other agency and also with the provider for mutual agreement of the proposed placement. If a mutual agreement cannot be reached, the next conference must be held with the director or his or her designee per item 4 above. Should any special needs of an individual being presented for placement has implications for the health, safety and care of other individuals in the home, those needs must be considered by both agencies and the provider, with due regard for confidentiality.

b). Conditions for Respite - In those instances where the individual served by either agency must be placed under emergency conditions, the placing agency must give notification at the earliest possible time (that business day, or at latest, the next business day).

6). Conditions for Removal of Individuals from the Home:

Upon removal of an individual from a home, the service coordinator must notify the assigned liaison staff for both the local DDSO and _____ agency initially by telephone and subsequently by correspondence.

7). Cancellation of Agreement:

The agreement may be terminated by either party within thirty (30) days written notice.

Approved by _____ Date _____
Director or Designee

Approved by _____ Date _____
Agency Director or Designee

After initial certification for the operation of a Family Care home, certification must be renewed at least every three years by OMRDD through the DDSO. The DDSO may, at their discretion, recertify a home for less than three (3) years. The expired, terminated, revoked or invalid certificate must be returned to the local DDSO. Homes certified prior to March 26, 1990 must be presumed to have demonstrated compliance with the safety, and welfare requirements for the purpose of certification. If a requirement is more rigorous than what was previously required under the appropriate section of the 1984 *New York State Uniform Fire Prevention and Building Code,* and results in unreasonable hardship, the home based on previous compliance, is to be considered in compliance.

As vacancies occur in Family Care homes certified for more than four individuals, those vacancies may not be filled, and the certified capacity is to be reduced. Only the DDSO director, based on a clinical evaluation of the family and home, and with the approval of the associate commissioner (or his or her designee), can approve an increase beyond a capacity of four or fill vacancies in a home serving more than four individuals. (Reference Policies 10.3.4 A and 10.3.4B).

Individuals can remain in a Family Care home only if there *is a current, and valid operating certificate or a renewal application has been properly submitted* in a timely manner.

No operating certificate may be renewed by the commissioner (or his or her designee) unless there is satisfaction as to the adequacy of the premises, equipment, applicant's financial resources, his or her ability to provide services to the individual(s) living in the home, and his or her having met the minimum required training or any additional training requirements of the sponsoring agency over a period of the operating certificate.

The guidelines for recertifying a Family Care home are as follows:

The provider must:

1. Complete Form 240 Reaffirmation Statement for Recertification, if there are no significant changes in the home since the last completion of the LS 22 Application for Family Care Home Certification. If there have been significant changes, the LS 22 must be completed.

2. Submit (or have the physician submit) the Physician Statement and other testing and immunization requirements consistent with OMRDD's current policy for persons providing direct care to individuals with developmental disabilities.

3. Arrange with the Family Care Home Liaison a fire and safety inspection conducted by the DDSO in accordance with 14NYCRR Section 635-7.4, using Form 236 ADM. or Form 236A (MR-Revised December 2000) *Family Care Home Survey For One-and-Two Family Dwellings or Form 236A for Multiple Dwellings.*

4. Have a written fire evacuation plan ensuring that fire drills are conducted on at least a monthly basis, and that drills are held at different times during the day and/or evening.

5. Ensure, with sponsoring agency staff, that arrangements have been made with other providers of services for the provision of health, habilitation, day services, education, employment, transportation or other services as may be necessary, and appropriate to meet the needs of individuals who will continue to reside in the Family Care home.

6. Sign the *Statement of Prohibition of Abuse and Neglect* (Ref. Policy 10.3.1G).

7. Complete and sign, along with all other adults in the home, the State Central Register Clearance Form (Reference Policy 10.3.1F) that allows the sponsoring agency to inquire of the New York State Office of Children and Family Services if the provider or other adults in the home have been the subject of an indicated child abuse or maltreatment report.

RESPONSIBILITY	PROCEDURE
Family Care Coordinator/Designee	1. Mails or has the Family Care Home Liaison deliver the Family Care Recertification Packet 90 days before an expiration date to the provider which includes the *LS 22 Application for Family Care Home Certification* or *Form 240 Reaffirmation Statement for Recertification.* The Form 240 is completed if there have been no significant changes in the home.
	2. Checks the provider and all adults living in the home through the State Central Register.

	3.	Notifies safety or code enforcement officer or DDSO Certification staff who inspects the home by completing Form 236 or Form 236A and the plan of correction, if necessary.
Family Care Provider	4.	Completes the LS 22 Application for Family Care Home Recertification, only, if there have been significant changes in the home; otherwise, completes the Form 240 Reaffirmation Statement for Recertification with other requested materials in a timely manner.
Family Care Home Liaison	5.	Reviews the previous six months of Form 239 and the previous Form 238 and provides a narrative, with recommendations, to the Family Care Coordinator or the DDSO Certification staff.
Family Care Coordinator\Designee	6.	Reviews the recertification packet for accuracy and completeness.
	7.	Schedules follow-up visit to work with the provider to rectify any deficiencies and completes Plan of Correction.
	8.	Compiles, when all requirements are satisfied, the recertification packet and forwards it to the DDSO Non-Family Care Certification staff.
DDSO Non-Family Care Certification Staff	9.	Reviews the recertification packet and forwards, with written recommendations that includes verification of the information on Form 238 by either completing the form or conducting an on site visit to the Family Care home, to the DDSO Director or his or her designee (Non-Family Care staff).

DDSO Director or Designee (Non-Family Care Staff)	10. Reviews and approves for capacities of one to four individuals or existing capacities of five (5) or six (6). Sends a letter of approval with original (new) operating certificate to the Family Care provider.
	11. Sends, if the provider is not recertified, a letter of denial with a copy to the Office of Counsel, advising the provider of reason(s) for denial. If necessary, schedules a meeting with the provider.
	12. Sends to associate commissioner or his or her designee, the request and the recommendation for approval to increase capacity or fill a vacancy for more than four individuals. (Reference Policy 10.3.4 A)
Family Care Coordinator/Designee	14. Must ensure that the Social Security # of the provider be verified prior to submittal to ISS. It is imperative that the SS # in TABS is a VALID number and is that of the Family Care provider.
	15. Ensures the completion of Policy Form 10.3.5 *Family Care Home Registration Form (ref Policy 10.3.5)*, and that a copy is forwarded (E-MAIL) to Information Support Services (Please Note: the DDSO staff enters Demographic changes, Program name changes, Recertification, and Closings. **Do Not Send These Requests To COOPCERT.**

Each Family Care home must be inspected in accordance with 14 NYCRR Section 687.7 by authorized OMRDD staff as frequently as necessary. Inspections will be made on at *least two occasions* during the calendar year after the individual has permanently moved into the home. One of these inspections *must be without prior notice by DDSO staff* knowledgeable of the Family Care Program and the Family Care provider. It is recommended that the announced inspection be completed using Form 236 or 236A. Whenever possible all inspections, and/or investigation should be made when the individuals are home or just prior to their arrival from a day services.

When conducting an inspection or investigation, OMRDD has the authority to inspect the Family Care home, (all areas) conduct interviews with individuals in the home, interview other parties residing in the home, examine, and copy all records including an individual's financial, and medical records; and obtain any other information required to ensure compliance with applicable requirements.

In conducting any inspection or investigation, the Commissioner or his or her designee, is authorized to subpoena witnesses, require their attendance, administer oaths to witnesses, examine witnesses under oath, and require the production of any books, papers, or other documentation deemed relevant to the investigation, inspection, or hearing.

All inspections, and investigations must be made by staff knowledgeable to conduct these activities. Information obtained by OMRDD staff during an inspection or investigation must be kept confidential in accordance with the provisions of the Mental Hygiene Law and other applicable provisions of law.

The express purpose of the unannounced visit is to conduct an evaluation of the home based on Form 238 ADM. MR. *Family Care Home Evaluation and Survey*. The Form 238 must be completed in its entirety and marked accurately. Observations, concerns or deficiencies must be noted under the comment section. For example, community inclusion was not completed due to the illness of the individual. If appropriate, any discussion or recommendation(s) with the provider must be noted under the comment section. The completed form must be kept at the sponsoring agency in the provider's record. Staff, completing the form, must notify the Family Care Coordinator, Family Care Home Liaison, non-Family Care staff or other appropriate staff of all findings noted during any of these inspections, for follow-up, where indicated. Form 238-POC is to be used when corrective action is necessary. If Form 238 is being completed for recertification, the review must be completed or confirmed by an onsite visit by non Family Care Staff (reference Policy 10.3.4).

FAMILY CARE HOME EVALUATION AND SURVEY

State of New York
OFFICE OF MENTAL RETARDATION
AND DEVELOPMENTAL DISABILITIES

FAMILY CARE HOME EVALUATION AND SURVEY
OMR-Form 238 ADM (MR) (Rev. 12/00)

Form must be completed on at least **an *ANNUAL*** basis.

Mark all that apply.

PURPOSE: **Date** \ \

- ☐ **Recertification**
- ☐ **State Sponsored**
- ☐ **Agency Sponsored**
- ☐ **Unannounced Visit**
- ☐ **Announced Visit**

Operating Certificate Number

I. PROVIDER INFORMATION

A. Primary Provider _____ Sponsoring Agency _____

Address _____ Address _____

_____ _____

Telephone ( ) _____ Telephone ( ) _____

Secondary Provider _____ Contact _____

Telephone ( ) _____ Telephone ( ) _____

B. Does the provider own the home? ☐ Yes ☐ No, explain _____

_____

General condition of the home and grounds: ☐ Good ☐ Needs Repairs ☐ Other, specify _____

C. Annual Family Income Source of Income

D. Family Composition
Spouse ☐ Living at home
☐ Living elsewhere, explain
_____
_____

Children
☐ Living at home No. ____
☐ Living elsewhere

Boarders: No. _____
Placed by: ☐ DSS ☐ DFY
☐ OMH ☐ CWA
☐ Other, specify _____
_____

Name/Occupation of each person in the home	Business Address/Telephone	Relationship to Provider(s)
Husband		
Wife		
Others		

II. INFORMATION ON FAMILY CARE INDIVIDUAL(S)

A. Name of individual(s) currently living in the home.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

B. Characteristics of individual (s): Ethnicity _____ / _____ Sex ( ) Male ( ) Female

_____ Ambulatory _____ Non-ambulatory _____ Hearing Impaired _____ Visually Impaired

Ages 0 - 5 _____ 6 -18 _____ 19-21 _____ 22-35 _____ 36-50 _____ 51-64 _____ 65 and older _____

III. HOME AND ENVIRONMENTAL INFORMATION

A. CHARACTERISTICS OF THE HOME	YES	NO	COMMENTS
a. Does the number of individuals in the home exceed the certified capacity?			
b. Do individuals from any other agency reside in the home? If Yes,	___	___	
1. Is there a written agreement between each agency director defining the terms and conditions of sharing the home?	___	___	
2. Do any of these individuals require personal care or oversite from the family care provider?	___	___	
3. If YES, please explain under comments.			
c. Does the provider reside at the same address, within the same living unit, not a separate apartment?			
d. Are furnishings and equipment adequate and safe for size and needs of both family members and individuals?			
e. Are comfortable chairs and appropriate other furnishings available for individuals' leisure time?			
f. Is the interior of the home in acceptable condition? (Do walls need painting, tile in need of repair, and is flooring torn or soiled requiring replacement?)			
g. Is there an adequate supply of hot and cold water?			
h. Are individuals' rooms adequately heated by a central heating source?			
i. Is housekeeping adequate?			

CHARACTERISTICS OF THE HOME CONT'D	YES	NO	COMMENTS
j. Is each individual's bed and furnishings in good condition, with adequate linens?			
k. Are kitchen supplies and food properly stored?			
l. Does the home meet the needs of those individuals with physical, sensory or behavioral disabilities? If No, please explain under comments.			

B. SUPERVISION	YES	NO	COMMENTS
a. Are residential habilitation plans understood and implemented by the family care provider as written?			
b. Is supervision of each individual's activities apparent, as provider describes activities?			
c. Are individuals who require help in activities given assistance by provider?			
d. Is the provider knowledgeable of the where abouts of individuals when they are away from the home? And the approximate time of their return?	___	___	
e. Has the provider received any training in the past year? If YES, please list courses under comments. If NO, please explain under comments.	___	___	
f. Is an approved respite provider, known and liked by the individuals and acceptable to the Family Care Coordinator, available for primary provider's absences? Date of Approval _____			

SUPERVISION CONT'D	YES	NO	COMMENTS
g. Has respite provider received training based on the needs of the individual(s)?			
h. Has respite been provided since the last visit? Emergency _____ Planned _____			
i. If YES, has the staff met the approved respite provider?			
j. Was respite provided in the home? Or at an approved location?	___	___	
k. How long was respite service provided? _____			
l. If longer than five consecutive days, did staff visit the home to ensure health, safety, etc? Date of visit _____			
C. INTERACTION WITH HOUSEHOLD	**YES**	**NO**	**COMMENTS**
a. Do individuals eat in a family setting with family members? If not, please explain.	___	___	
b. Are individuals involved in recreation and other activities with family members?			
c. Does each individual have leisure activities and appropriate equipment for such activities?			
d. Are the leisure/recreational activities consistent with the individual's ISP and Residential Habilitation Plan?			
e. Do activities take place in the community?			
f. Has there been any significant change in the home that may impact on the individual(s)? i.e., a divorce, loss of a job, loss of the lease. If YES, please explain.			

D. HEALTH AND MEDICAL CARE	YES	NO	COMMENTS
a. Is a careful record of medication taken by each individual kept by the provider and is it available for review?			
b. Is informed consent being implemented as required?			
c. Is supervision of medication administration appropriate to meet the individual's needs as documented in the ISP?			
d. Is storage provided for personal medication?			
e. Are prescriptions filled timely?			
f. Any medication changes this month?			
g. If YES, has the new medication been started?			
h. If YES, did the individual (s) suffer any adverse effects?			
i. If YES, does the provider feel knowledgeable with new medication, instructions/sideeffects?			
j. Are individuals' medical needs being met (medical and dental appointments made and kept, nursing visits made on at least a quarterly basis)?			
k. Any physicians, dentist, or medical specialist visits this month?			
l. If YES, explain the reason for the visit.			
m. Any instances of individual illness this month?			
n. Do individuals receive appropriate meals and snacks according to dietary needs, at appropriate times, in a normal manner and not altered or denied for disciplinary purposes?			
o. Do individuals have a choice in selecting meals and snacks?			
p. Do individuals receive appropriate personal hygiene, such as tooth brushing, hair grooming, etc., with assistance as necessary as identified in the Residential Habilitation Plan?			

E. PRIVACY	YES	NO	COMMENTS
a. Are each individual's personal possessions readily accessible, available and adequate? If not, please explain under comments.	___	___	
b. Is there an area for the individual to visit with family and friends?			
c. Does each individual have access to private areas where she or he can be alone?			
d. Do any individuals share a bedroom? If Yes, are there more than TWO individuals in a bedroom?	___ ___	___ ___	
e. Have any changes in sleeping arrangements been reported? If YES, please explain?			
f. Is there any evidence that individual sleeping arrangements have been changed since last visit? If Yes, please explain.			

F. RIGHTS OF THE INDIVIDUAL	YES	NO	COMMENTS
a. Has the Medicaid Service Coordinator visited the home during the past three months? (Except for those enrolled in P.O.C.S).			
b. Is there any indication that any of the individuals are abused or neglected or isolated from other individuals or provider (i.e., assaulted, verbally abused, or in any unnecessary way restrained)? If YES, please explain under comments.			
c. Has it been necessary to complete an incident report during the past 3 months? If YES, for what?			

RIGHTS OF THE INDIVIDUAL CONT'D	YES	NO	COMMENTS
Place a check "Yes" or "No" for each response:			
d. Have the following individual rights been limited for disciplinary purposes or for the convenience of the provider?:			
i. To have visitors and to visit outside the home.	___	___	
ii. To communicate by letter or telephone without censorship.	___	___	
iii. To access family planning services.	___	___	
iv. To attend religious services of the individual's choice.	___	___	
v. To have the opportunity to participate in religious activities and to have visits in the home from clergy and other religiously affiliated persons.	___	___	
vi. To choose to not to participate in religious activities if she or he so wishes.	___	___	
vii. To contact their Medicaid Service Coordinator.			
e. Is transportation available by provider or others to support all components of the Individualized Service Plan (ISP) and/or the Residential Habilitation Plan (RHP)?			
f. Do individuals have choices in the way they save and spend their personal allowances and/or earnings?			
g. Is there evidence of individual expenditure planning or a Personal Expenditure Plan (PEP) on behalf of the person? If NO, please explain under comments.			
h. Does the provider maintain an updated expenditure record with receipts as necessary for individual funds?			
i. Do individuals have sufficient and appropriate clothing for a week's wear?			
j. Is clothing clean and appropriate to age, season, and selected by the individual?			
k. Are individual(s) clean and well groomed?			
l. Are there adequate personal hygiene supplies for each individual?			

INDIVIDUAL	CASH ON HAND	BANK ACCOUNT (Is this a training account?)

G. PHYSICAL PLANT	YES	NO	
a. Are there smoke detection devices, with a visible indicator of the alarm being energized?			
b. Are smoke detectors installed in each corridor adjacent to bedrooms? Or in bedrooms in homes built after July 1995?			
c. Are smoke detectors installed in corridors or in an adjacent open area, such as a living room, dining room or recreation room, at a maximum of thirty feet on center and no more than fifteen feet from a wall?			
d. Is a smoke detector installed at the head of each open stairway located within the home or within six feet of the bottom opening of a stairway that is enclosed at the top?			
e. Has each smoke detection device been tested monthly?			
f. Is there at least one 2A10BC (6lb.) fire extinguisher in or near the kitchen area? Has the provider been trained to use it?	___	___	

PHYSICAL PLANT CONT'D	YES	NO	COMMENTS
g. Does the home contain any of the following?			
1. Portable space heaters? Location? Have they been approved by the sponsoring agency for a time limited period?			
2. Kerosene for heating or lighting? If YES, contact safety officer to ensure a safe condition exists.			
3. Vermin or insect infestation, etc.?			
h. Is there a fire evacuation plan?			
1. If YES, is it rehearsed monthly with all individuals or family members in the home?			
2. Is it rehearsed at different times of the day, based on the needs of the individuals?			
3. Has a drill been observed by the Family Care Home Liaison?			
i. 1. Are any bedrooms located in an attic?			
2. Are any bedrooms above the second floor? (Apartment building - N/A)			
3. Are any bedrooms located below grade or in a cellar? If YES, please explain.	___	___	
j. Are bedroom(s) adequate in size to provide a reasonable degree of privacy, and for the individual(s) furnishings and possessions? (e.g., bed, dresser, comfortable chair, personal items)?			
k. Are bed rails used and have they been approved by the DDSO?			
l. Is the residence either a mobile home or trailer?			

PHYSICAL PLANT CONT'D	YES	NO	COMMENTS
m. Are all dangerous household products, flammable liquids, and chemicals stored in such a way to ensure, to the extent possible, denial of inappropriate access or danger of combustion?			
n. Is there an accumulation of combustible material in closets, attics, basements, garages, or other parts of the dwelling?			
o. Is trash and garbage kept in plastic or metal containers with properly fitted covers and disposed of on a regular basis?			
p. Are extension cords in use? If YES, are they overloaded; in traffic areas which presents a safety hazard; strung together to reach an outlet; under carpets, or otherwise used improperly?	___	___	
q. Does the home contain any hazardous conditions, (e.g., loose tiles, loose hand-rails, worn stair treads, loose or torn carpet, burned-out bulbs, exposed wiring, unvaccinated/unlicensed pets, etc.)?			
r. Does the home contain clutter (e.g., piles of newspaper, magazines, old furniture, boxes, clothing, etc.) that may pose a fire, fire evacuation or trip hazard to individuals? If YES, please specify.			
s. 1. Is the provider making or planning to make any modifications to the home?			
2. If YES, what modifications are being made?			
3. Are modifications free of hazardous physical conditions?			
4. Has a building permit been issued and/or has a certificate of occupancy been issued for this work?			
t. Is the home equipped with a GFCI at the bathroom and kitchen sinks?			
u. Are there anti-scald devices as required? If NO, has a waiver been issued by the DDSO?			
v. Do you recommend that this home be inspected by staff trained in physical plant inspections?			
w. If YES, explain why under comments section.			

IV. COMMUNITY INFORMATION

A. TYPE OF NEIGHBORHOOD

☐ Residential ☐ Commercial ☐ Industrial ☐ Rural ☐ Mixed

B. ACCESSIBILITY OF HOME TO:

(Explain any lack of accessibility. In addition, please confirm the individual's use of community facilities.)

i.	School	☐
ii.	Church	☐
iii.	Employment	☐
iv.	Stores	☐
v.	Hospitals	☐
vi.	Social/Recreational Activities	☐
vii.	Public Transportation	☐
viii.	Other needs (Specify)	☐

V. GENERAL COMMENTS. { Please note any deficiencies with recommendation(s)}

VI. RECOMMENDATION(S)

Recertification ☐ **Yes** ☐ **No** ☐ **With Corrective Action** ☐ **With Limitations**

If YES, non Family Care Staff must complete Form 238 or confirm via an on site visit to the home.

Print Name of Person Completing the Form _____

Print Title of Person Completing the Form _____

Signature of Person Completing Form _____ Date _____

Print Name and Title of Reviewer _____

Signature of Reviewer _____ Date _____

PLEASE NOTE: If the staff completing this form is a Family Care Home Liaison, please indicate the date of verification visit by QA/QS Staff _____ Date _____

Comment(s)

Form 238 - Rev. 6/02
cc: Family Care Provider File

FAMILY CARE INSPECTION REPORT PLAN OF CORRECTION

Family Care Provider: _____ **Address:** _____

_____ **Inspection Date** _____

CHECKLIST NUMBER	PLAN OF CORRECTION	PLANNED DATE OF COMPLETION	COMPLETION DATE

Form 238 - POC Rev. 12/00
cc: Family Care Provider
Provider File

_____
Signature of Family Care Provider Date

_____
Signature and Title of Person(s) Responsible for Corrective Action Report Date

_____
Signature and Title of Person(s) Reviewing Form 238 and Responsible for Plan of Correction Date

PLEASE COMPLETE THIS SECTION FOR WILLOWBROOK CLASS MEMBERS ONLY

	YES	NO	COMMENTS
A. Does the Class Member have a Medicaid Service Coordinator who is a Qualified Mental Retardation Professional (QMRP)? If No, Please explain under comments.			
B. Does the Medicaid Service Coordinator's case ratio meet the guidelines of the Willowbrook Permanent Injunction? (1:20 for Family Care) If NO, please explain under comments.			
C. Is the Willowbrook Class Member, who is non-correspondent or who is lacking active Participation by a correspondent, receiving "active representation or co-representation" by the Community AdvisoryBoard? If NO, please explain under comments.			
G. Does the Willowbrook Class Member's Permanent file contain the "Notice of Rights statement, describing individuals' rights and entitlements under the Permanent Injunction? If NO, please explain under comments.			

Recommendation(s)	
Completed by Name	Title
Reviewed by Name	Title

Form 238 Addendum WP1 12/00

Each Family Care home must be visited in accordance with 14 NYCRR Section 687.7 as frequently as necessary, but no less than once per month. One of these visits may be held quarterly in conjunction with the individual, provider, and Medicaid Service Coordinator to assess the individual's progress, issues, and/or concerns in both the home and day services.

The monthly home visit, conducted by the Family Care Home Liaison, should be scheduled when the individual (s) is home or just prior to their arrival. Any observation(s) made during this time is to be documented on *Form 239 Family Care Monthly Checklist* and placed in the provider's file. The required monthly Residential Habilitation note may be documented on Form 239-FC/Monthly Note (ref. Page 14 of Form 239). Any issues related to a specific individual may be documented on a form used by the sponsoring agency and placed in the individual's file. Any observations requiring follow-up, must be documented on Form 239-POC and discussed with the Family Care Home Liaison's immediate supervisor for corrective action. The sponsoring agency's monthly visit made by Family Care Liaison may include, but is not limited to:

1. Evaluating, in relation to safety, and future certification, the appropriateness of the home.

2. Obtaining any information necessary to ensure compliance with applicable physical plant requirements.

3. Assessing the appropriateness of each individual's activities based on the Residential Habilitation Plan, and documenting that Residential Habilitation Services are being delivered in accordance with the Residential Habilitation Plan (RHP).

4. Conducting interviews with those living in the home to ascertain, among other things:

    a. Any events in the family's life that would affect the provider's ability to deliver services to the individual(s) living in the home. These events would include illness, separation, divorce, domestic violence, loss of income, income executions, new family member, or other actions or proceedings requiring the involvement of law enforcement officials.

b. Any needs of the individual such as medical, psychological, social, personal, recreational, that are not currently being met.

c. Any concerns, and/or issues the individual is experiencing at home such as behavior, medical or restrictions from participating in religious or cultural activities of his or her choice.

d. Any difficulties the individual has experienced in day services, and/or related activities, particularly as they pertain to the individual's emotional, and social adjustment, and continued stay in Family Care.

5. Reviewing the Personal Allowance Ledger monthly to ensure the appropriateness of expenditures with receipts as required.

6. Reviewing, and copying all related records, including financial and medical records, as necessary. Obtaining other information required to ensure compliance with applicable requirements. All information obtained during monitoring or during an investigation will be kept confidential.

7. Contacting the Family Care provider via the telephone, within two (2) days of the provider's initial notification to the sponsoring agency regarding the individual's illness/absence from day services. Visiting the Family Care home, if the individual is absent from day services for five consecutive days, unless absences are planned (vacations) or known (hospitalizations or post hospitalizations), to monitor the individual's well being, and to determine if the individual or provider requires additional assistance.

8. Advising the Family Care provider of any changes to payments, policies and/or administrative requirements by the sponsoring agency.

The Family Care Home Liaison must discuss any changes noted during the monthly visit that requires action and/or follow-up with the Family Care Coordinator/Team Leader. Any deficiencies requiring corrective action must be listed on the Form 239 *Family Care Inspection Report Plan of Correction* and sent to the Family Care provider for corrective action. Documentation of the correction or lack of by the Family Care provider is required.

On a quarterly basis the Family Care Home Liaison must:

1. Assess any environmental changes by conducting a walk-through of the entire home to monitor for structural modifications, safety violations, and any indications of changes in family composition.

2. Review the Personal Allowance Ledger, Personal Expenditure Plan (PEP) and count cash-on-hand. Staff must verify that cash-on-hand is consistent with the balance noted in the ledger and does not exceed the limit established regulations. Any observations, concerns or deficiencies must be noted on Form 239-POC.

The Family Care Coordinator, Team Leader or other staff must immediately be informed of any findings indicating that an individual's health and/or safety is in imminent danger or that there exists any condition or pattern of conditions or practices which pose an imminent danger to any individual (ref. Section 10.7.4 Responsibilities Family Care Home Liaison).

State of New York OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES OMR - Form 239 Rev. December 2000	FAMILY CARE PROGRAM MONTHLY CHECKLIST **Instructions: To be completed on a monthly basis. All deficiencies must be reported to appropriate staff and followed up in a timely manner.**

Date _____ \ _____ \ _____ Time _____ ( ) A.M. ( ) P.M. Individuals Present Yes ( ) No ( )
MSC Present Yes ( ) No ( )

Family Care Provider _____ Address _____

_____ Telephone # _____

Individuals in Residence _____ _____ _____

_____ _____ _____ _____

Family Care Home Liaison _____ Telephone Number _____

Medicaid Service Coordinator _____ Telephone Number _____

I. PHYSICAL PLANT		YES	NO	COMMENTS
1.	a. Are all smoke detection units operating?			
	b. Have they been tested as required?			
2.	a. Are all fire extinguishers operable?			
	b. Have they been inspected and tested as required (i.e., at least annually)?			
3.	a. Are there any space heaters in use?			
	b. Location _____			
	c. Fuel _____			
	d. Approved by sponsoring agency for time limited period?			

	PHYSICAL PLANT	YES	NO	COMMENTS
4.	a. Are extension cords in use?			
	b. If YES, are they overloaded, in traffic areas which present a safety hazard, string together to reach an outlet, or otherwise used improperly?			
5.	Are dangerous household products and flammable liquids stored properly so as to avoid safety hazards?			
6.	a. Is there a fire evacuation Plan?			
	b. Are fire drills conducted monthly and at different times during the day and evening? If NO, please explain under comments.			
	c. Are drills conducted with all family members present? If NO, please explain under comments.			
7.	Does the home contain any hazardous conditions, (e.g., loose tiles, loose handrails, worn stair threads, loose or torn carpet, burned out bulbs, garbage not properly contained, unlicensed or unvaccinated pets, etc.)?			
8.	Does the home contain clutter, (e.g., piles of newspapers, magazines, old furniture, boxes, clothing, etc.), that may pose a fire, fire evacuation or trip hazard to individuals?			
9.	Is the home equipped with the required GFCI at the bathroom and kitchen sinks? Anti-scald device installed at the shower/tub? Or is there a mixing valve or another device installed at the water heater? Please explain under comments.			

II. INDIVIDUAL SERVICES		YES	NO	COMMENTS
1.	Are individuals clean, well-groomed and given the opportunity of choice on clothing selections?			
2.	Are individuals assisted with personal hygiene and grooming, as necessary, and in accordance with the Residential Habilitation Plan?			
3.	a. Are individuals' beds and furnishings in good condition, with adequate sheets pillowcases, and blankets on hand?			
	b. Is the individual's room personalized and/or based on his or her preference?			
	c. Are bed rails being used? If so, were they approved by the DDSO?			
4.	a. Is there any indication that any of the individuals are isolated, abused or neglected?			
	b. Has it been necessary to complete an incident report this month?			
	c. If YES, please explain under comments.			
5.	Do individuals and provider(s) interact as a family? (e.g., dining, community activities).			
6.	a. Have any changes in sleeping arrangements been reported?			
	b. Is there any evidence that sleeping arrangements have been changed since last month?			

	INDIVIDUAL SERVICES	YES	NO	COMMENTS
	c. Were there any changes in the individual's sleeping pattern?			
7.	Are Residential Habilitation Plans understood and being delivered by the provider? (Family Care Home Liaison must document delivery of Residential Habilitation Services by completing a monthly service note). Are community inclusion goals being met (ref. VI, page 10 of this form)?			
8.	Is the provider knowledgeable of the whereabouts of individuals when they are away from the home and the approximate time of their return?			
9.	Are any of the individuals capable of being left alone for a few hours?			
10.	If YES, is this reflected in the ISP and the Residential Habilitation Plan?			
11.	Were there any unusual changes in bus schedule or problems with day services or employment?			
12.	If YES, please specify under comments.			
III	**HEALTH CARE CONSIDERATIONS**	**YES**	**NO**	**COMMENTS**
1.	Are individuals' medical needs being met (i.e., medical dental, and psychological appointments made and kept)?			
2.	Are nursing visits made on at least a quarterly basis?			
3.	a. Any physician, dentist or medical specialist visit(s) this month?			
	b. If YES, explain the reason for the visit(s).			
4.	a. Any instance of illness or hospitalization?			
	b. If YES, explain the reason for the hospitalization.			

	HEALTH CARE CONSIDERATIONS	YES	NO	COMMENTS
5.	a. Any medication changes this month?			
	b. If YES, has the medication been started?			
	c. If YES, did the individual suffer any adverse effects?			
	d. If YES, is the provider knowledgeable with the new medication instructions and side effects?			
6.	Is supervision of medication administration appropriate to meet the individual's needs as documented in the Individualized Service Plan (ISP)?			
7.	a. Is a careful record of medication taken by each individual kept by the provider?			
	b. Is the record available for review?			
	c. If NO, please explain under comments.			
	d. Are medications listed by dosage, route, time?			
	e. Are prescriptions filled timely?			
	f. If NO, please explain under comments.			
8.	a. Are diets appropriate to the individual needs, and:			
	i. served at appropriate time?			
	ii. served in a normal manner?			
	iii. altered or denied for disciplinary purposes?			

IV. GENERAL		YES	NO	COMMENTS
1.	a. Is the overall appearance of the home and grounds acceptable?			
	b. Are there any signs of vermin or insect infestation?			
2.	a. Is there any evidence of modifications or renovations to the home?			
	b. Have modifications or renovations been reported to the DDSO?			
3.	a. Has respite been required this month?			
	b. If YES, has staff met the approved respite provider?			
	c. Was respite provided in the home?			
	d. If NO, where?			
	e. How long was respite service provided?			
	f. If longer than five consecutive days, did staff visit the home to ensure health, safety, etc.?			
	g. Has the Family Care provider provided over night respite in the home this month?			
4.	a. Has the certified capacity of the home been exceeded?			
	b. How many people, including consumers and family members, are living in the home?			

	GENERAL	YES	NO	COMMENTS
	c. Were or are there boarders or visitors?			
	d. If YES, specify under comments.			
	e. Were any members added to the family? If YES, were they included in the fire drill?			
	f. If YES, if 18+ years of age, was the person checked through the State Central Register?			
	g. Have appropriate persons been Finger Printed in accordance with OMRDDs Policies and Procedures?			
	h. If NO, please explain under comments.			
5.	a. Has the provider attended any training this month?			
	b. If NO, please explain under comments.			
	c. Was training provided by the sponsoring agency?			
	d. If NO, please indicate who provided training?			
	e. Please list type of training, i.e., ongoing, specialized, other.			
	f. List courses, training, etc., under comments			

	GENERAL	YES	NO	COMMENTS
6.	a. Have there been any significant changes in the home that may impact on the individual(s) such as divorce, health issues, loss of income, legal involvement, actions or proceedings).			
	b. If YES, please describe under comments.			

V. FISCAL

		YES	NO	COMMENTS
1.	Does the provider maintain expenditure records that are updated as needed, with receipts as necessary for each of the individual(s)?			
	a. Clothing, personal supplies and other incidentals.			
	b. Personal Allowance.			
2.	Does the individual have a training bank account? If YES, is the account in the individual's name?			
	a. If YES, has the bankbook been updated?			

FISCAL	YES	NO	COMMENTS
b. Does the individual have cash on hand?			
c. If YES, please specify below and note any instance where the amount exceeds the regulatory limit.			

INDIVIDUAL	CASH ON HAND	BANK ACCOUNT

V1. COMMUNITY INCLUSION ACTIVITIES DURING THE MONTH: Please list the individuals' name and activity (ies).
1.
2.
3.
4.
5.
6.
7.
8.

VII. DEFICIENCIES, CORRECTIVE ACTION, FOLLOW-UP (Has deficiency (ies) on any safety problems been addressed?)

Rev. 12/00 Form 239-POC

VIII. COMMENTS

NOTE: A repeated NEGATIVE response to items 1,2,5,and 6 and/or a POSITIVE response to item 3, 4, 7 and 8 under Section I, Physical Plant, indicates that the home must be visited by trained safety or quality assurance staff.

Family Care Provider _____ Date _____
(Signature)

Family Care Home Liaison _____ Date _____
(Print Name)

_____ Date _____
(Signature)

Family Care Coordinator/Designee _____ Date _____
(Print Name)

Team Leader _____ Date _____

Other DDSO Staff _____ Date _____
(Print Name)

Rev. 12/00 Form 239
cc: Family Care Provider and Provider File

FAMILY CARE INSPECTION REPORT PLAN OF CORRECTION

Family Care Provider: _____ Address: _____

_____ Inspection Date: _____

CHECKLIST NUMBER	PLAN OF CORRECTION	PLANNED DATE OF COMPLETION	COMPLETION DATE

Rev. 12/00 Form 239 -POC
cc: Family Care Provider and Provider File

_____
Signature of Family Care Provider Date

_____
Signature and Title of Person Responsible for Corrective Action Date

_____
Signature and Title of Person Reviewing Form 239 and Plan for Corrective Action Date

MONTHLY FAMILY CARE NOTE

Family Care Provider: _____ Address: _____

Name of Individuals: _____

Name of Medicaid Service Coordinator: _____ Was the MSC notified of any issues/concerns? ( ) Yes ( ) No

Signature of Family Care Home Liaison: Date Completed:

Form 239 - FC/Monthly Note

Under the Sponsoring Agency Family Care Home Visitation Plan the Family Care Program must accomplish the following:

1. Monthly visit, using Form 239, to each Family Care home should be scheduled when the individual(s) is home or just prior to arriving from day program.

2. Quarterly face-to-face visit with each individual by the Medicaid Service Coordinator, exception for those enrolled in the P.O.C.S.S.

3. One annual inspection, using From 236 or 236A and one unannounced visit to each Family Care home using Form 238.

4. Quarterly visit by the nurse or more frequently if warranted.

Form 239 and Form 238 must be maintained in the Family Care provider's record. Documentation of nursing visits must be filed in the individual's record.

In those instances where staff assigned the visitation responsibility are absent, the sponsoring agency staff responsible for the Family Care Program oversite, must ensure that another staff member makes the monthly visit knowledgeable of Family Care.

The Sponsoring Agency Family Care Coordinator or other designated staff must implement an internal audit process using the attached or similar form. The Family Care Coordinator or other designated staff must conduct bimonthly reviews to perform a 10% audit of Family Care records to ensure that documentation is contained in the record, and that issues of compliance, and other concerns have been addressed.

FAMILY CARE VISITATION SCHEDULE

CONSUMER	NAME OF FCP	FACE-TO-FACE (Month)	FC HOME (Month)	UNANNOUNCED (Annual)	PROGRAM (Quarter)	NURSE (Quarter)	SAFETY

Form FC-418

Month _____ Year _____ County _____ Completed by _____ Date

Each Family Care provider must have access to at least one approved substitute provider who is available to provide short-term substitute services when the provider is in need of relief or is absent from the home. The substitute provider, if living in the home, must be age 18. If the substitute provider is living outside the Family Care home the person must be age 21 or older. Exception, the substitute provider may be approved at the age of 18 if they have experience and training in human services (i.e., College student matriculating in nursing, social work, psychology, pt, ot, special education).

Sponsoring agency staff must ensure the frequency of training and that training for both initial and reapproval are held at a time and location convenient for substitute providers. The sponsoring agency staff must also ensure that there is a central entry point or staff person who has been identified to receive and review the substitute provider packet. This person must also be able to provide information/status to applicants. It is essential that all training is documented in Staff Development and Training (DT) system for any training conducted by the DDSO staff.

Approval Process:

The substitute provider, prior to providing services, must be approved by the sponsoring agency. The substitute provider must:

1. Complete *Form LS 22 A, Application for Substitute Providers.*

2. Submit a medical statement from a physician, nurse practitioner or physician assistant, indicating that he or she has been seen within the past twenty-four (24) months, and is in good physical and mental health. Medical statement must include all required testing consistent with OMRDD policy for volunteers.

3. Have, if respite will take place in the home, their home surveyed to ensure that all safety guidelines are met, using *Form 236R-(ADM) for One-and-Two Family Dwellings or Form 236RP-(ADM) for Multiple Dwellings.* If the home is not routinely used *AND* visited by DDSO staff, staff must visit the home on an annual basis. The substitute provider must notify the DDSO staff if there have been any changes in family composition or any significant environmental changes.

4. Complete the Statement of Prohibition of Abuse and Neglect.

5. Receive 10 hours of initial training in the following areas: fire safety (video or classroom instruction), reportable incidents and abuse (classroom instruction or instructor present), techniques in first aid (class room instruction or instructor present), emergency medical techniques (class room instruction or instructor present) to include assessing emergency services, administration of medication, infection control and Heimlich Maneuver.

6. Request from the sponsoring agency Family Care Staff, an exemption of specific topic areas, if the applicant(s) holds a Registered Nurse or Licensed Practical Nurse degree, Emergency Medical Technician (EMT), Physician Assistant or has received training as a direct care staff.

Documentation of training or licensure must be maintained in the substitute provider's file. Regardless of prior training or exemption status, the substitute provider must be required to *attend training sessions* on reportable incidents and abuse, or other topics in the core OMRDD curriculum. Specialized training may also be required based on the needs of the individual(s)in the home or the needs of the substitute provider.

Upon completion of all training requirements, a certificate *(Form OMR 135B Approved Substitute Provider)* will be issued by the sponsoring agency director, and will be valid for up to three (3) years.

Relatives or friends who may be called upon, in an emergency or unexpected situation, to provide respite for a short duration (never overnite and never longer than a few hours, and not on a regular or routine basis) are not required to complete the *LS 22 A - Application for Substitute Providers.*

(For payment process - see *Policy 10.8.6 Emergency Respite Services and Policy 10.8.7 Payment for Substitute Provider Services).*

Reapproval Process

The substitute provider must have five (5) hours of training upon renewal of the *Certificate of Approval.* The following requirements must be met:

The substitute provider must:

1. Submit a medical statement indicating that he or she has been seen by a physician or physician assistant or nurse practitioner within the past twenty-four months, and is in good physical and mental health. Medical statement must include evidence of all required immunization.

2. Sign the Notice of Abuse and Neglect Form.

3. Receive training in the following areas:

   a. Abuse and Neglect (classroom instruction)
   b. Fire Safety (video or classroom instruction)
   c. Techniques in First Aid (classroom instruction)
   d. Administration of Medication (classroom instruction)
   e. One hour specialized training as defined by the sponsoring agency.

4. Have, if substitute services will take place in the home, their home surveyed to ensure that all safety guidelines are met using Form 236R for One and Two Family Dwelling, and Form 236RP -ADM for Multiple Dwelling.

State of New York OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES **Application for Approval** **SUBSTITUTE PROVIDER** **Initial or Reapproval** **OMR LS 22 A - Rev. 10/05**	Instructions to Applicant(s): ▪ Completes and signs one copy of the LS 22 A – *Application for Approval/Reapproval* and sends to Sponsoring Agency Family Care Coordinator or Designee for review and follow up. ▪ Applicant(s) must complete ten hours of initial training prior to receiving the *Certificate of Approval* or five hours for Reapproval. ▪ If substitute service will occur in the applicant(s)' home, OMRDD must conduct the necessary physical plant and home evaluation. ▪ The home must meet all physical plant requirements. ▪ If approved, a *Certificate of Approval* will be issued for of up to three (3) years.

(For Sponsoring Agency Use Only)

Initial Approval: Date of Approval ___/___/___ State Sponsored ___ Agency Sponsored ___

Reapproval: Date of Reapproval ___/___/___ Agency Name/DDSO _____

I. PROVIDER INFORMATION

A. Name of Applicant

_____

B. Address

_____

Street City County Zip Code

Mailing Address if different

_____

Street City County Zip Code

C. Telephone Number(s)

Land Line _____ Cellular _____

(Home Telephone)

D. Current Marital Status ☐ Married ☐ Never Married ☐ Separated ☐ Widowed ☐ Divorced

Social Security # Applicant _____

E. Religion

☐ Protestant ☐ Catholic ☐ Jewish ☐ Jehovah's Witness ☐ Muslim ☐ None ☐ Other specify _____

F. Primary Language

☐ English ☐ Spanish ☐ Sign ☐ Other spoken, specify _____

G. Education (circle highest grade completed)

School 1 2 3 4 5 6 7 8 9 10 11 12

College 1 2 3 4

Grad School ☐ Yes ☐ No

Professional License ☐ Yes ☐ No

Type _____

Name and address of high school or college

_____

_____

H. Attach an employment history, together with a signed release for employment verification.

I. Applicant's Driver's License

License No. _____

Issuing State _____

Expiration Date _____

Please provide information regarding any moving violations, including alcohol and drug-related offenses.

Indicate any suspension, revocation or occurrence involving harm to human beings or property.

_____

_____

_____

_____

_____

J. Name and age of each person, including the applicant, living in the home and relationship to the applicant. (**Only required if services are to be delivered in the substitute provider's home**).

Name	Date of Birth	Relationship

K. Attach a physician's statement indicating that the applicant is in good health and physically and emotionally capable of providing Family Care services, along with all required testing.

II. PERSONAL REFERENCE/INFORMATION

A. Name and Address of 3 people NOT related to the applicant who can attest to the applicant's character.

1) _____

Name

_____

Street City Zip Code

2) _____

Name

_____

Street City Zip Code

3) _____

Name

_____

Street City Zip Code

B. Have you ever been approved, denied, licensed, or certified under present or any other names by any state, county, or private agency to provide services in the home? ☐ Yes ☐ No If Yes, please describe.
☐ Approved ☐ Denied ☐ Licensed ☐ Certified

C. Have you ever been convicted of a crime (misdemeanor or felony)? ☐ Yes ☐ No If Yes, please provide information on the crime, including date of conviction and court of jurisdiction. You may also supply information about your good conduct and rehabilitation.

D. Have any members of your household ever been convicted of a crime (misdemeanor or felony)?
☐ Yes ☐ No If yes, please provide the name of the household member and information on the crime, including date of conviction and court of jurisdiction. You may also supply information about the person's good conduct and rehabilitation. (**Only required if services are to be delivered in the substitute provider's home.**)

E. Are you currently the subject of any pending criminal charges? ☐ Yes ☐ No If yes, please provide information on the crime, and date of charge.

F. Are any household members currently the subject of any pending criminal charges? ☐ Yes ☐ No
If yes, please provide the name of the household member, information on the crime, and date of charge. (**Only required if services are to be delivered in the substitute provider's home.**)

G. Why do you want to become a Substitute Provider? _____

_____

_____

_____

_____

_____

_____

H. What life experiences do you have with individuals with developmental disabilities? Please explain.

_____

_____

_____

_____

_____

_____

_____

I certify that all information included in this application is accurate and true to the best of my knowledge and understand that any untrue statement, knowingly given, is grounds for disapproval.

_____ _____

Signature of Applicant Date

Print Name of Person Reviewing the Form _____

Print Title of Person Reviewing the Form _____

Signature _____ Date Reviewed _____

Approved by _____ Title _____ Date of Approval_____

Date of Disapproval _____ Further Action Required ☐ Yes ☐ No

Comments

_____

_____

_____

_____

_____

STATEMENT OF PROHIBITION OF ABUSE AND NEGLECT

I, _____, substitute provider for the _____Family Care Home, under the auspices of _____ sponsoring agency (DDSO or ASFC), have read, and fully understand the content in 14 NYCRR Part 624 Reportable Incidents, Serious Reportable Incidents, and Abuse. I further understand that I cannot, and will not, in any manner, cause harm to any individual living in this home or receiving substitute care in my home. I further understand that I must, within 24 hours, report all incidents, i.e., abuse, neglect, injury, or leave without consent to the local DDSO.

Failure on my part to uphold the guidelines in 14 NYCRR Part 624 or OMRDDs policies, and procedures, may constitute the suspending or revoking or terminating of the above provider's operating certificate, and prohibit me from providing substitute services for any Family Care provider.

Signed: _____ Date:_____
Substitute Provider

Signed:_____ Date: _____
DDSO Staff

State of New York OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES OMR-FORM-236R-ADM. Rev. 1/03	FAMILY CARE SUBSTITUTE PROVIDER HOME SURVEY FOR ONE-AND-TWO FAMILY DWELLINGS

Date _____ Inspector _____ Name Substitute Provider _____

Address _____ Address _____

Sponsoring Agency _____ Zip Code _____ ( ) Telephone _____

☐ Initial Approval ☐ Reapproval

Have there been changes to the home since the last survey? ☐ Yes ☐ No

Approximate age of home _____ Gross Square Feet Per Floor: Basement

First Floor_____ Second _____ Type of Construction:

Attach a floor plan upon initial approval and include dimensions of each bedroom and occupant(s) of each bedroom.

PLEASE NOTE: If the home undergoes new construction additions or other alterations requiring a building permit, a copy of the building permit and certificate of occupancy from the local building department must be obtained.

A. RESIDENT SLEEPING SPACES	YES	NO	IF NO, COMMENTS
1. Is there access to each bedroom without going through another bedroom?**			
2. Are the attic, stair hallway(s), hallway(s), or any room(s) commonly used for other than bedroom purposes free of beds? **[635-7.4(a)(2)(iii)(e)(ii)]***			
3. a. Is natural light and ventilation provided in each bedroom?** b. Is there a window that can be opened in each bedroom for use in an emergency?			

B. HABITABLE SPACES (Living, Sleeping, Eating, or Cooking)	YES	NO	COMMENTS
4. Do habitable spaces have natural light and ventilation?**			
5. Do habitable spaces have electric light appropriate for intended use?**			
6. Are all habitable spaces no more than 4'0" below average grade?**			

C. NON-HABITABLE SPACES (pantries, toilet, laundry, storage, utility, hallways and stairways, and garages)	YES	NO	COMMENTS
7. Are bathrooms arranged to provide privacy? **[635-7.4(b)(1)(I)]***			
8. Do nonhabitable spaces have electric light appropriate for intended use?**			
9. Are kitchenettes and bathrooms provided with natural or mechanical ventilation?**			
10. If there is glass in showers and tub enclosures, is it safety glass?			

D. ALL SPACES	YES	NO	COMMENTS
Electrical			
11. Is wiring firmly supported or in a conduit?**			
12. Are all fuses and circuit breakers of the proper size?**			
13. Are wires free from fraying or insulation cracking?**			
14. Are there enough outlets to prevent makeshift wiring and use of extension cords?**			

Heating, Ventilating, Air Conditioning and Fuel Storage	YES	NO	COMMENTS
15. If a wood stove exists, does it meet the installation standards of NFPA 211, or the manufacturer's installation requirements?			
16. Do steam radiators and pipes have protective shields? **[635-7.4(a)(2)(iii)(g)]***			
17. a. Is heating equipment and fuel storage safe and operable?** b. If a wood stove/fireplace exists, is it maintained in a safe manner? c. Are there any portable space heaters? If yes, please comment. **[635-7.4(a)(2)(iii)(b)]***			
18. Do portable fire extinguishers meet NFPA 10 and are UL approved and labeled? **[635-7.4(a)(2)(iii)(f)]*** Note: For clarification, extinguisher to be type 2A 10BC (as a minimum). One extinguisher is to be in or near the kitchen on that floor.			

Stairs	YES	NO	COMMENTS
19. Do stairways have a handrail on at least one side?**			
Smoke Detectors	**YES**	**NO**	**COMMENTS**
20. a. Are smoke detectors installed in each corridor adjacent to sleeping rooms or in sleeping areas of a home built after July 1995? **[635-7.4(a)(2)(iii)(e)(l)]***			
b. Are smoke detectors installed in corridors or in an adjacent open area, such as a living room, dining room or recreation room, at a maximum of thirty feet on center and no more than 15 feet from a wall? **[635-7.4(a)(2)(iii)(e)(1)]***			
c. Is a smoke detector installed at the head of each open stairway located within the home, or within six feet of the bottom opening of a stairway that is enclosed at the top? **[635-7.4(a)(2)(iii)(e)(2)]***			
d. Is at least one smoke detector installed at the head of the basement stairs? **[635-7.4(a)(2)(iii)(e)(3)]***			
e. Is the basement partitioned? If so, are there adequate smoke detectors installed? **[635-7.4(a)(2)(iii)(e)(3)]***			
f. Is the accessible and usable attic partitioned? If so, are there adequate heat detection units installed? **[635-7.4(a)(2)(iii(e)(iii)]***			
g. Are all smoke detectors clearly audible in sleeping areas with intervening doors closed?**			

Environmental	YES	NO	COMMENTS
21. Do ventilation windows contain removable screens?			
22. Does the home have telephone service? **[635-7.4(a)(2)(iii)(c)]***			
23. If the water supply is private, has the water been tested at least once in accordance with Department of Health (or authority having jurisdiction) requirements for private homes?			
24. Are general plumbing systems safe, sanitary and in serviceable condition?**			
25. Is the door(s) from the house to an attached garage tight fitting a self- closure?			
26. Are structural members protected and maintained to resist and prevent deterioration?**			
27. Is dwelling free of obvious safety hazards? **[635-7.4(b)(iv)]***			
28. Is housekeeping adequate and is the house free of clutter?			

Exterior Property	YES	NO	IF NO, COMMENTS
29. If there is an in ground pool of more than 24" in depth on the property, is there an approved enclosure or equivalent that controls access? (The enclosure may surround either the pool area or the property.)**			
30. Are grounds free of obvious safety hazards?**			
31. Is groundwater appropriately drained to protect buildings?**			
32. It is recommended that the following issues be considered, as appropriate or indicated, based on the conditions of either the building or people in the home. Examples (not all inclusive): Environmental testing: Asbestos Radon Termites Lead paint Safety measures: Anti scalding devices Electrical ground fault interrupters (GFI)			

Mobile Homes	YES	NO	COMMENTS
33. a. Did the provider furnish a copy of verifying documentation that the home is a 1976 model or newer?			
b. Is the Federal Housing, Education and Welfare seal (a red metal seal attached to home at time of construction) installed on the outside of the house, verifying that the unit was constructed to HUD standards?			
c. Can the applicant provide a copy of the occupancy certification certifying compliance with NYS UFPBC Part 1223 Installation Procedures?			

GENERAL COMMENTS:

Inspected by: _____

PRINT NAME

_____ _____

Signature Date

Reviewed by: _____

Signature

Comment(s) _____

* OMRDD Regulatory requirements that must be met.
** NYS Uniform Fire Prevention and Building Code. Subchapter F.

SUBSTITUTE PROVIDER SURVEY REPORT
PLAN OF CORRECTION

Substitute Provider _____ **Address:** _____

_____ **Survey Date:** _____

CHECKLIST NUMBER	PLAN OF CORRECTION	PLANNED COMPLETION DATE	DATE COMPLETED

POC- Form 236R 08/04
cc. Substitute Provider File

_____
Signature Substitute Provider (Optional) Date

_____
Signature and Title of Persons Responsible for Corrective Action Report

New York State Office of Mental Retardation and Developmental Disabilities FORM - 236 SP-ADM (MR) 08/04	SUBSTITUTE PROVIDER HOME SURVEY FOR MULTIPLE DWELLINGS

Date Inspector Name of Substitute Provider

Address Sponsoring Agency Address Substitute Provider

Zip Code Telephone # Zip Code Telephone #

( ) Initial Approval ( ) Reapproval Have there been changes to the home since the last survey? ( ) Yes ( ) No

Type of construction: _____ Number of stories: _____ Approximate age of building _____ years.

Type of multi-family unit: _____ Mixed-use _____ 3 - 4 units _____ 4-8 units _____ Over 8 units

Approximate gross square footage of residence _____ square feet. What floor is residence on? _____

Name of people who live in the residence: _____

_____, _____, _____

_____, _____, _____

Attach a floor plan upon initial approval and include dimensions of each bedroom and occupant(s) of each bedroom:

Bedroom 1 _____ Bedroom 2 _____ Bedroom 3 _____

Bedroom 4 _____ Bedroom 4 _____ Bedroom 5 _____

A. CONSTRUCTION TYPE	YES	NO	COMMENTS
1. Are dwelling units separated by fire-rated construction in accordance with the building code requirements of the community for existing multiple dwellings?			
2. If this is a multi-use building, is there an appropriate rated separation between the other occupancy and the residence?			
B. EXITS	**YES**	**NO**	**COMMENTS**
3. Are there at least two separate means of egress from the corridor outside of the dwelling unit? ***			
4. Are all stairways and corridors illuminated? **			

	YES	NO	COMMENTS
5. Is there emergency lighting provided in exits?			
6. Are exit and directional signs illuminated? **			
7. a. Are fire escapes or exterior stairs used as a required means of exit? b. If yes, do they comply with local code requirements? **			
8. If exit corridor is longer than 100', is there a smoke stop?			
9. Are all exits unlocked or unfastened so that there is free, unobstructed departure from inside the building?			
10. Do dwelling unit corridor doors have self-closing doors?			
11. Are corridors, walls and doors fire-rated in accordance with building codes?			
12. If exit stairway from upper floors continues to a basement, is there a mechanism to prevent unintentional exit travel to the basement?			
C. APPROVED BEDROOMS	**YES**	**NO**	**COMMENTS**
13. Do all bedrooms have a minimum width of 7'0"?			
14. Do the windows open onto a open space that allows escape from a fire?*			
15. Is there access to each bedroom without going through another bedroom?**			
16 Are the attic, stair hallway(s), hallway(s), or any room(s) commonly used for other than bedroom purposes free of beds?*			
17. Is natural light and ventilation provided in each bedroom?**			
18. Is there an operable window in each bedroom for emergency use? **			

D. HABITABLE SPACES (Living, Sleeping, Eating or Cooking)	YES	NO	COMMENTS
19. Do habitable spaces have natural light and ventilation?**			
20. Do habitable spaces have electric light appropriate for intended use?**			
21. Are all habitable space no more than 4'0" below average grade?**			

E. NON-HABITABLE SPACES (pantries, bathrooms, kitchens) ?	YES	NO	COMMENTS
22. Are bathrooms arranged to provide privacy?*			
23. Do non habitable spaces have electric light appropriate for intended use?**			
24. Are kitchens and bathrooms provided with natural or mechanical ventilation?**			
25. If there is glass in showers and tub enclosures, is it safety glass?			

F. ALL SPACES	YES	NO	COMMENTS
26. Is wiring firmly supported or in a conduit?**			
27. Are all fuses and circuit breakers of the proper size?**			
28. Are wires free from fraying or insulation cracking?**			
29. Are there enough outlets to prevent makeshift wiring and use of extension cords?**			

G. HEATING, VENTILATING, AIR CONDITIONING AND FUEL STORAGE	YES	NO	COMMENTS
30. Do steam radiators and pipes have protective shields? *			
31. Is heating equipment and fuel storage safe and operable?**			
32. Are there no portable space heaters (except for emergency use?)*			
H. STAIRS	**YES**	**NO**	**COMMENTS**
33. Do stairways have a handrail on at least one side?**			
I. FIRE SAFETY	**YES**	**NO**	**COMMENTS**
34. Are smoke detectors installed in each corridor adjacent to bedrooms?*			
35. Are smoke detectors installed in corridors or in an adjacent open area, such as a living room or dining room, at a maximum of thirty feet on center and no more than 15 feet from a wall?*			
36. Is the fire alarm system centralized?			
37. Do portable fire extinguishers meet NFPA 10 and are UL approved and labeled?* Note: For clarification, extinguisher to be type 2A 10BC (as a minimum). One extinguisher is to be in or near the kitchen on that floor).			
J. ENVIRONMENTAL	**YES**	**NO**	**COMMENTS**
38. Do ventilation windows contain removable screens?			
39. Does the home have telephone service?*			
40. Is there an adequate supply of water (both quantity and temperature)? **			

	YES	NO	COMMENTS
41. Are the general plumbing systems safe, sanitary and in serviceable condition?**			
42. Is there one toilet, sink and tub/shower for every six people who live in the home?			
43. Are structural members protected and maintained to resist and prevent deterioration?**			
44. Is the dwelling free of obvious safety hazards?*			
45. Are grounds free of obvious safety hazards?**			
46. It is recommended that the following issues be considered, as appropriate or indicated, based on the conditions of either the building or people in the home. Examples (not all inclusive): Asbestos Radon Termites Lead paint Safety measures Anti-scald devices Electrical ground fault interrupters (gfi)			

Recommendation(s)

* Regulatory and OMRDD Requirement
** New York State Uniform Fire Protection and Building Code
*** Not a Requirement, but must be Seriously Considered.

GENERAL COMMENTS:

Substitute Provider must notify DDSO staff at (_____) _____ of any significant environmental changes or changes in family composition that have occurred in the home since the last survey.

One copy is sent to the approved Substitute Provider.

Inspected by: _____

_____ Signature

_____ Date

* OMRDD Regulatory requirements that must be met.
** NYS Uniform Fire Prevention and Building Code. Subchapter F.

SUBSTITUTE PROVIDER SURVEY REPORT
PLAN OF CORRECTION

Location _____ **Survey Date** _____

CHECKLIST NUMBER	PLAN OF CORRECTION	PLANNED DATE COMPLETION	COMPLETED DATE

SP-POC236

_____
Signature and Title of Person (s) Responsible for Corrective Action Report

December 2000	FAMILY CARE SCHEDULED ABSENCES FROM HOME	Policy 10.4.7

In keeping with the "Family" concept, which is an integral part of the Family Care Program, OMRDD considers it appropriate for individuals living in Family Care to accompany the provider on family vacations, if the individual so chooses. If an individual chooses not to accompany the provider on vacation, or the provider would like to use this vacation as a respite from Family Care responsibilities, the sponsoring agency must assist that individual, and the provider with alternative living arrangements. Family Care providers who are caring for school age children attending state education programs should be discouraged from taking these children on vacation while school is in session.

While it is not feasible for OMRDD to ensure that vacation sites maintain the same standards as Family Care homes, as an agency, OMRDD is obligated to assure that all possible steps are taken to protect, to the extent possible, the safety and well being of individuals during their vacation periods with a Family Care provider.

In instances where a Family Care provider owns or rents a vacation home, cottage or condominium, the Family Care provider must submit to the sponsoring agency, every three years, documentation that the home in which they will be living meets the environmental and fire safety standards and that this has been verified by the state or municipality in which the home is located.

Prior to taking an individual on vacation, a Family Care provider must notify his or her Family Care Home Liaison as well as the individual's Medicaid Service Coordinator of his or her intention. This notification must be made at least six weeks prior to the intended date of departure. The Medicaid Service Coordinator must document the following information in the individual's record:

1. The name, the address and the telephone number of the vacation location.

2. The dates of the vacation.

3. The consent of the parent/guardian, if appropriate, and

4. A copy of the emergency medical plan.

The Medicaid Service Coordinator, Family Care Home Liaison, Family Care provider, nurse, and individual must discuss the financial arrangements for the trip consistent with the Personal Expenditure Plan (PEP), as well as address any issues regarding medical

needs, need for prescription and medical coverage while on vacation. Medicare and New York State Medicaid, benefits do not necessarily cover the individual in case of a medical emergency while abroad. Since the individual does not have any other health insurance, the DDSO or sponsoring agency will be responsible for the cost of medical expenses. Prior to international travel, the appropriate DDSO or sponsoring agency staff need to explore if the travel agency offers trip related medical coverage for overseas travel. In addition, the Family Care provider must submit to the sponsoring agency an emergency plan that will be put in action should the provider become unable to care for the individual(s) or if the individual(s) condition becomes such that the provider is unable to care for him or her. The plan must indicate that the sponsoring agency will be notified immediately should the need arise.

Absences for More than 30 (Thirty Days):

An extended absence poses additional monitoring and programmatic difficulties, and must, therefore, be carefully evaluated. If the individual chooses, with the approval of the sponsoring agency, family and advocate, to accompany the provider on vacation exceeding 30 (thirty days), and a visit cannot be made during the month, the sponsoring agency must discontinue Difficulty of Care (DOC) payments to the Family Care provider unless oversight provisions can be made that are acceptable to the sponsoring agency.

A written agreement must be in place with an agency or professional in the field of mental retardation and developmental disabilities that assures face-to-face visit(s) at least twice a month to the provider's temporary residence to verify that Residential Habilitation Services are being delivered in accordance with the individual(s) Residential Habilitation Plan (RHP) developed from the Individualized Service Plan (ISP). This verification must be in writing on either Form 239 Monthly Checklist or a form being used by the agency/professional and forwarded to the sponsoring agency on a monthly basis. The sponsoring agency staff must maintain telephone contact with the individual and provider on at least a monthly basis to determine if there are any needs or issues to be addressed.

The cost for verification of the services is the responsibility of the Family Care provider. The sponsoring agency staff may provide technical assistance or contacts in other states. Under no circumstances will DOC checks be sent to an out-of-state address.

Listed below are the procedures a provider must follow if a provider desires to leave his or her home with an individual living in that home for a prolonged period.

RESPONSIBLE	PROCEDURE
Family Care Provider	1. Makes a written request, at least six (6) weeks prior to the intended date of departure, to the Family Care Home Liaison and Medicaid Service Coordinator, to take an individual who resides in the Family Care home on vacation.
	2. Indicates the name, address and telephone number of the vacation location, the intended dates of the vacation and information about the vacation home or unit in which the family will reside.
	3. Submits to the sponsoring agency an emergency plan that will be put into place should the provider become unable to care for the individual or should the individual's condition becomes such that the provider is unable to care for him or her.
Family Care Home Liaison	4. Convenes, in conjunction with the Medicaid Service Coordinator, a meeting with the individual's team to discuss the provider's request and makes recommendations to extend the leave period based on the individual's needs, choices and preferences.
	5. Notifies the provider of the team's decision at least three weeks prior to making final arrangements for the intended vacation. If the team's decision is that an extended stay is

not in the best interest of the individual, the sponsoring agency staff must assist the provider with alternative living arrangements.

6. Notifies, in conjunction with the Medicaid Service Coordinator, the individual's parent, guardian, advocate, and/or correspondent, as well as, day services, of the individual's planned extended stay.

7. Notifies the local Office of Revenue Support of the intended stay and all fiscal issues, including receipt of Supplemental Security Income (SSI), food stamps and Difficulty of Care payments. Payment for medical treatment must be resolved prior to departure.

8. Reviews, in conjunction with the nurse, emergency medical procedures including payment for medical treatment.

9. Plans in conjunction with the Family Care Provider, Medicaid Service Coordinator, and individual, where feasible, the use of personal allowance funds.

Family Care Provider

10. Makes accommodations, with the assistance of the Family Care nurse, if needed, for emergency situations, and ensures that the individual's medical needs will be addressed.

Vacation Costs:

If a provider chooses to arrange and provide a vacation that is specifically for the individual/s in his or her home, certain costs may be shared by those individuals (Family Care provider, provider's family and individuals - see Policy 10.7.11-*Recreational Trips*).

The following are cost guidelines:

A. **Shared Costs:**

1. Cottage/Condominium or Time Share Rental.
2. Gas for the provider's automobile, with receipts.
3. Tolls and parking receipts.

B. **Family Care Provider's Costs:**

1. The costs of food to prepare meals and the costs of routine meals at a restaurant since the provider would normally be providing meals to the individuals.
2. The costs of the provider's lodging (hotel/motel room).
3. Any costs associated with the provider's ownership of a cottage, condominium, or time share.
4. Any costs associated with staying at the home of relatives or friends.

C. **Individual's Costs:**

1. The costs of some of the individual's meals at a restaurant (limit to be set prior to vacation).
2. The costs of the individual's recreational activities, i.e., amusement parks, miniature golf, movies, etc.
3. The costs of the individual's lodging (hotel/motel), if the individual has his or her own room or shares the room with another individual.

Individuals may use a percentage of clothing/personal and incidental needs funds to offset the costs of their vacation, if there is not a current clothing need.

NOTIFICATION OF VACATION OR EXTENDED ABSENCES FROM THE HOME

I, _____, residing at _____

will be vacationing with the individual(s) residing in my home from _____

to _____. We will be staying at the _____

located in _____. If there is a need to contact me, you may

reach me at _____.

Signature of Provider _____ Date _____

OR

I, _____, residing at _____

will be vacationing in, from _____ to _____. The individual(s) will be

cared for by _____ at _____. Although the respite

provider has been given all pertinent information, should you need to reach me under any

circumstance, please contact me at _____.

Signature of Provider _____ Date

SECTION 10.5

SUSPENSION, REVOCATION AND LIMITATION OF AN OPERATING CERTIFICATE

10.5.1 Voluntary Termination

10.5.2 Failure to Comply with Requirements

10.5.3 Return of the Operating Certificate

The certificate holder must notify the certifying DDSO, and the sponsoring agency of any intention to voluntarily terminate the operation of a Family Care home. This intention may be made verbally as soon as such a decision has been reached, but written notice must be sent to the DDSO at least 60 days prior to an intended closing date. Such written notice must include the anticipated date of closing, and the reason(s) for closing. The requirement for prior written notice does not apply to those situations and changes in circumstances directly affecting the Family Care provider that are not reasonably foreseeable at the time of occurrence, including, but not limited to, the death or sudden incapacitating disability or infirmity of the Family Care provider, or fire, a flood, etc.

The notice is to include a detailed plan developed in conjunction with the DDSO, and the sponsoring agency which makes provision for the staff to assist each individual served by the Family Care provider to move into a home appropriate to each individual's ongoing needs and preferences.

The Family Care provider is to continue providing services until the notice and plan are received, reviewed, and approved by the DDSO, and the individuals are moved to another home. The DDSOs review and approval must be accomplished within 15 business days after receipt of the plan to ensure DDSO collaboration in the preparation and finalization of the plan, and to minimize any delay in processing the request.

FAMILY CARE
NOTIFICATION FOR
TEMPORARILY SUSPENSION **Policy 10-5.1A**

HAND DELIVER AND CERTIFIED MAIL
RETURN RECEIPT REQUESTED

_____
(date)

{provider's name and address}

_____
_____
_____

Dear _____

In accordance with Section 16.17(b) of the Mental Hygiene Law, this letter constitutes formal notification that your operating certificate issued to you by the Office of Mental Retardation and Developmental Disabilities for the provision of Family Care services at the above address has been temporarily suspended effective _____ {date}. This action and the removal of the person(s) receiving services from your home on _____ {date} is based on a finding by OMRDD that there exists in your home a condition or practice which poses an imminent danger to the health or safety of such persons (s). If you would like to discuss this action, please call _____ at _____.

You have the right to an administrative hearing to appeal this temporary suspension of your operating certificate. You also have the right to be represented by an attorney at such a hearing. In order to have such a hearing, you must request it in writing within 10 days of your receipt of this letter, to:

Paul R. Kietzman, Esq.
General Counsel
New York State Office of Mental Retardation
and Developmental Disabilities
44 Holland Avenue
Albany, New York 12229

Your written request for a hearing <u>must include a copy of this letter.</u> You should also submit a copy of your request to me. You have the right to have this hearing within 10 days of your written request.

Later determination. Section 16.17(b) of the Mental Hygiene Law allows OMRDD to impose this temporary suspension for up to 60 days. Whether or not you choose to have a hearing on the temporary suspension at this time, a determination will be made during this 60-day period whether to reinstate, suspend, limit or revoke your operating certificate.

Should it be determined during that 60 day period to suspend, limit, or revoke your operating certificate, you will receive a separate notice of determination, and you will have the right to have an administrative hearing to appeal that determination. Your right to such an appeal will not be affected by whether or not you ask for the more immediate hearing on the temporary suspension imposed by this letter. However, if you do have a hearing on any such determination to suspend, limit, or revoke, the temporary suspension would continue through the outcome of that hearing.

Sincerely,

_____
Director

cc. Office of Counsel

December 2000	FAMILY CARE FAILURE TO COMPLY WITH REQUIREMENTS	Policy 10.5.2

The Operating Certificate of a Family Care home may be revoked, suspended, temporarily suspended, limited, not renewed, or penalties imposed upon a determination that the Family Care provider named on the certificate has failed to comply with the terms of the Operating Certificate or with the provisions of any applicable statute, rule or regulation. The Family Care provider must be given notice, and an opportunity to be heard prior to any such determination, except under emergency suspension or limitation of the Operating Certificate.

OMRDD must revoke, based on Mental Hygiene Law Section 16.17(f), an Operating Certificate when upon finding that the Family Care provider has been convicted of a class A, B or C felony or a felony related in any way to any activity or program subject to the regulations, supervision or administration of the OMRDD or by the Office of Children and Families; the State Department of Health, State Department of Substance Abuse or violations of the Public Officers Law.

The Mental Hygiene Law allows OMRDD to revoke the Operating Certificate if the felony conviction was within ten (10) years. Because of the nature of Family Care, the sponsoring agency needs to know about everyone in the household. For example, a husband who is not proposed to be on the Operating Certificate, had been convicted of a felony more than ten (10) years ago. The sponsoring agency must consider how long he has been out of prison, and has he had more problems with the criminal justice system. If his record has been clean for an extended time, and he otherwise appears to be the type of family member OMRDD expects in a Family Care home, and all other guidelines are satisfactory, the sponsoring agency has the discretion to issue the Operating Certificate.

On an initial or renewal, the sponsoring agency has the option of issuing the Operating Certificate for less than the maximum three-year term. If the felony conviction was more then ten (10) years ago the Commissioner or his or her designee cannot revoke or limit the Operating Certificate on the felony alone.

A temporary suspension or limitation without a prior hearing, for a period not to exceed of *60 days,* may be made upon written notice to the Family Care provider following a finding by OMRDD or the local DDSO that an individual's health or safety is in imminent danger, or there exists any condition(s) or practice(s), or a continuing pattern of conditions which

poses imminent danger to the health or safety of any person. Upon such finding and written notice, OMRDD can temporarily suspend or limit an Operating Certificate to include, but not be limited to:

1. Prohibiting or limiting the placement of new individuals in the Family Care home.

2. Removing or causing to remove some or all of the individuals in the Family Care home.

3. Suspending or limiting the payment of any governmental funds to the Family Care home, provided that such action does not jeopardize the health, safety, and welfare of any individual residing in the Family Care home.

During a *sixty-day (60)* suspension or limitation period, OMRDD will determine whether to reinstate or remove the limitations on the Family Care provider's Operating Certificate, or to revoke, suspend or limit the Operating Certificate. If OMRDD decides to revoke, suspend or limit the Operating Certificate, then the emergency suspension or limitation remains in effect pending the outcome of an administrative hearing on the revocation, suspension or limitation.

The Family Care provider, within *ten days {10}* of the date when the emergency suspension or limitation is first imposed, may request an evidentiary hearing to contest the validity of the emergency suspension or limitation. The evidentiary hearing is to commence within ten days of receipt of the Family Care provider's request, and no request for an adjournment will be granted without the concurrence of the Family Care provider, the OMRDD, and the hearing officer. The evidentiary hearing will be limited to those violations of federal and state law and regulations that initially gave rise to the emergency suspension or limitation. A record of the hearing is made available to the Family Care provider upon request. If the commissioner determines to revoke, suspend or limit the Operating Certificate, no administrative hearing on that action will commence prior to the conclusion of the evidentiary hearing, the rendering of the hearing officer's report and the commissioner's final review and determination concerning the emergency suspension or limitation. The commissioner will issue a ruling within *ten days {10}* after the receipt of the hearing officer's report.

When the Family Care provider requests an opportunity to be heard, the commissioner must set a time and place for the hearing. A copy of the charges, together with the notice of the time, and place of the hearing, must be served in person or mailed by registered or certified mail to the Family Care provider at least *ten (10) days* before the date set for the hearing. The Family Care provider must file with the office, not less than *three (3) days* prior to the hearing a written answer to the charges.

At any time subsequent to the suspension or limitation of any Operating Certificate where the temporary suspension or limitation is the result of correctable physical plant or program deficiencies, the Family Care provider may request that the DDSO reinspect the Family Care home to redetermine whether a specific condition or practice continues to exist. Within *ten (10) days* of the receipt of such a request, the DDSO is to reinspect the Family Care home to redetermine whether a specific physical plant or program deficiency continues to exist. In the event that the previously found condition or practice has been eliminated, the suspension or limitation is to be withdrawn. If the condition or practice has not been eliminated, the DDSO is not required to reinspect the Family Care home during the emergency period of suspension or limitation.

The commissioner may impose a fine upon a finding that the holder of the certificate has failed to comply with the terms of the Operating Certificate or with the provisions of any applicable statute, rule or regulation. The maximum amount of a fine is *one thousand dollars ($1000).*

Suspension, revocation, limitation or temporary suspension of an Operating Certificate by the DDSO must be conducted in conformance with the manual, and forms provided by OMRDD's Office of Counsel. The Office of Counsel must be called prior to any such action being taken. If it is necessary to effectuate a temporary suspension after business hours or on weekends and/or holidays, Counsel's Office must be called on the first business day thereafter. (Reference Section 16.17 of the Mental Hygiene Law Suspension, Revocation, or Limitation of an Operating Certificate, and Cumulative Annual Pocket Part).

All Operating Certificates remain the property of OMRDD. When an Operating Certificate is revoked, suspended, or terminated, it is returned to the DDSO. However, if the DDSO, on behalf of the Commissioner, is going to reissue the Operating Certificate, or extend the in-effect period of the existing one, there is no regulatory or statutory reason why the provider must return the old certificate before being issued a new one.

SECTION 10.6

PROVIDER RESPONSIBILITIES

10.6.1	Code of Conduct
10.6.2	Responsibilities
10.6.3	Protection of Individual Rights
10.6.3A	Confidentiality
10.6.4	Notification to Sponsoring Agency Staff of Significant Events in the Individual's Life
10.6.5	Storage and Administration of Medication
10.6.6	Medication Records
10.6.7	Provision of Supplies and Services
10.6.8	Using Personal Allowance for a Group Purchase
10.6.9	Provider Medicaid Transportation
10.6.9A	State and Agency Sponsored Certified Provider Medicaid Transportation Reimbursement Procedure OMR Form 199
10.6.9B	State or Agency Sponsored Substitute Provide Reimbursement for Medicaid Transportation OMR Form 200
10.6.10	Reimbursement for Travel Related to the Individual's Residential Habilitation Plan

June 1998	FAMILY CARE CODE OF CONDUCT	Policy 10.6.1

Each Family Care provider contributes to providing the best possible care and services for individuals served in Family Care. Family Care providers must conduct themselves in a manner that does not adversely affect their availability and capability to fully perform their role and responsibilities. Providers are expected to conduct themselves in a manner that will assist the individual(s) in meeting specific goals as agreed upon in the Residential Habilitation Plan, will be in compliance with all Family Care regulations, policies, and procedures, and will be an asset to the Family Care Program, in general.

The following are in addition to the responsibilities outlined in Policy 10.6.2:

1. Individuals should always be treated in a manner that assures their personal, legal, and civil rights.

2. Individuals are to be treated with courtesy, dignity, and respect.

3. Family Care providers must not verbally or physically abuse individuals or otherwise mistreat them. There must be no use of physical punishment.

4. Individuals are to be treated in a way that acknowledges, and respects their religion, race, cultural diversity, sex, age, and creed.

5. Family Care providers are to ensure that the individual(s) does not use drugs unless prescribed by a physician. This includes over the counter medications, treatments, etc.

6. Family Care providers are required to report any abusive treatment or injuries immediately regardless of where it occurs (see *Policy 10.1.14-Incidents, Allegations of Abuse and Other Significant Events)*. Failure on the part of any provider will be treated as a serious breach of responsibility, and may jeopardize the provider's operating certificate.

7. Family Care providers may not form any inappropriate social relationships with an individual(s) in their care or engage in any sexual activity with them.

8. Family Care providers may not demonstrate or model inappropriate or unacceptable behavior to an individual.

9. Family Care providers may not borrow or take individual's property or monies for their personal use.

10. Family Care providers are to have no personal financial transactions between the provider and the individual that may be construed as exploitation or result in greater benefit to the provider than the individual.

Rev August 2004	FAMILY CARE RESPONSIBILITIES	Policy 10.6.2

The Family Care provider has the following responsibilities:

1. Notifying sponsoring agency of any events in the Family Care provider's life that would affect the provider's ability to deliver services to the individuals in the home. These events would include illness or injury that may compromise the provider's ability to deliver services or any change in household composition such as separation, divorce, or minor children moving into the home.

2. Notifying sponsoring agency of any legal involvement, actions or proceedings about or affecting any member of the household. This requirement covers, but is not limited to, any arrests, criminal investigations, restraining orders, orders of protection, income executions, lawsuits, separation agreements, and divorce proceedings involving or affecting any member of the household, and any calls made to the police, or visits made to the home by the police or other law enforcement officials.

3. Cooperating with the sponsoring agency staff in their inquiry and/or investigation of information contained from the Division of Criminal Justice Services (DCJS).

4. Ensuring that any substitute services provided in the home do not exceed the certified capacity of the Family Care home.

5. Residing in the same Family Care home as the individual, and not contracting with others to provide permanent care at that or another address.

6. Ensuring those members of the household have an interest in, and an acceptance of each individual residing in the home, as well as a desire to help them achieve personal growth. This involves integrating the care of the individual with the normal routine of family life, including mealtimes and social recreational activities.

7. Providing for an individual's needs, including:

   a. A safe and clean home environment.

   b. A reasonable degree of privacy in sleeping, and bathing areas.

   c. Adequate storage for an individual's personal belongings, which is easily accessible to the individual and/or provider.

d. Appropriate meals and snacks according to dietary needs, at appropriate times, in a normal manner, and not altered or denied for disciplinary purposes.

e. Receiving instructions on how to counsel individuals, and assisting them in making desired choices.

f. Involving the individual in the home in the normal rhythm of the family.

g. Giving individuals residing in the home an opportunity to eat meals outside of the Family Care home with others as a family unit, and ensuring, to the best of his or her ability that dietary needs are followed.

h. Any necessary assistance to an individual with personal hygiene and the activities of daily living.

i. Adequate, individually owned grooming and personal hygiene supplies, as well as, grooming and hygiene supplies that are commonly purchased for the family's use. These items may include shampoo, facial tissue, toilet tissue, toothpaste, bandages, etc. Items such as deodorant, combs, razors, sanitary napkins, hairbrushes, and toothbrushes are not commonly purchased for family use and may be purchased by the individual.

j. Bedroom furniture to include a bed and bed frame, a mattress and box spring, chest of drawers, or dresser, chair, and lamp or overhead lighting.

k. Adequate bedding to include sheets, pillowcases, pillows, blankets, mattress pads and bedspreads.

l. Adequate supply of towels and washcloths

m. Washing and drying an individual's clothing. Paying for dry cleaning basic clothing items that are labeled as "dry clean only" by the manufacturer. This must be done, at a minimum, once a year according to the existing regulations. Dry cleaning costs may be assumed by the individual where the individual has selected clothing items which are not considered basic clothing, e.g., dress coat, men's suit.

n. Supplies for mending clothing to include scissors, thread, and needles.

o. Recreational materials used in the home. Examples may include: scissors, glue, paper, puzzles, games, pencils, pens and colored markers.

p. The cost of basic cable service, if available, and used by the provider, and his or her family, as well as, the individual.

q. Token gift(s) for the individual's birthday, which may include a birthday cake if desired by the individual, etc.

8. Arranging for and encouraging an individual to participate in recreational, cultural, and social activities in the community according to his or her abilities and based on his or her choice.

9. Ensuring that there is individually owned clothing that fits properly, is maintained properly, and is appropriate for age, season, and activity; and ensuring the opportunity to be involved in the selection of that clothing.

10. Assisting individuals in making purchases according to their choices.

11. Being reasonably aware of an individual's whereabouts or activities at all times.

12. Ensuring and protecting an individual's rights in accordance with Policy 10.6.3. *Protection of Individual Rights* and 14 NYCRR Section 633.4

13. Maintaining confidentiality of all information regarding an individual.

14. Maintaining accounts of any individual's expenditures, where required.

15. Arranging for and accompanying the individual on routine and emergency medical and dental care and providing first aid care as needed.

16. Assisting, as a member of the team, in the development of appropriate services, and participating in semiannual and annual reviews of the Individualized Service Plan (ISP), the Residential Habilitation Plan (RHP) and the Personal Expenditure Plan (PEP).

17. Assisting individuals in meeting objectives as identified in the Individualized Service Plan (ISP), the Residential Habilitation Plan and the Personal Expenditure Plan (PEP).

18. Being reasonably accessible to the sponsoring agency staff for the purpose of discussing information and/or activities about an individual living in Family Care.

19. In consultation with and approval by sponsoring agency staff:

    a. Determining which individuals can function without supervision for varying periods of time, and ensuring that this information is included in the ISP.

    b. Providing an approved substitute provider, who is knowledgeable when emergencies necessitate an absence from the home. The substitute provider must meet the requirements of Policy 10.4.4

        i. Be age 18 or older with experience and training in human services (lives in the home, college student matriculating in nursing, social work, psychology, pt, ot, special education); or

        ii. Be age 21 without prior training or education.

    c. Ensuring that the supervisory needs of individuals in the home are met, and that no individual who is in need of supervision is left unsupervised.

20. Reporting significant events in the lives of individuals living in the Family Care home, regardless of where they occur, to sponsoring agency staff to include but not be limited to: illness, injury(ies), absences from day services, unexplained absences, death, increased behavior problems, doctors appointments (see *Policy 10.1.14-Incidents, Allegations of Abuse and Other Significant Events).*

21. Providing or arranging, in conjunction with sponsoring agency staff, the transportation of individuals to programs, schools, religious, social, and recreational activities, medical and dental appointments and any other necessary appointments or activities.

22. Seeking immediate medical services when an individual becomes ill, and arranging for emergency transportation to include ambulette or ambulance service.

23. Seeking immediate emergency medical services and following instructions provided when an individual living in Family Care appears to have died. The provider must notify the home liaison or the Administrator on Duty through the twenty-four (24) hour crisis telephone number, of the individual's death.

24. Notifying, in conjunction with identified sponsoring agency staff, the family members, and significant others of the individual's death; and making the necessary arrangements and dispositions as directed by the sponsoring agency.

25. Refraining from supervising individuals while under the influence of drugs or alcohol, which may impair the provider's ability and judgment to provide effective supervision. The use of illegal drugs is prohibited.

26. Ensuring that any firearms or weapons in the Family Care home are safely, and securely stored in locked cabinets without ammunition to prevent accidents or misuse.

27. Ensuring that dogs and cats residing in the household are properly immunized according to state requirements. Dogs residing in Family Care homes must be licensed annually.

28. Ensuring that all pets residing in or visiting the Family Care home are free from diseases and pose no harm to the individuals residing in the home. Animals and/or reptiles that have been taken from the wild, or are on the Federal Endangered or Threatened Species list are not allowed in Family Care homes. Venomous or poisonous snakes that require a license are not allowed in Family Care homes.

29. Ensuring that outside employment does not conflict with the provider's responsibilities to deliver services to individuals in the home. Arrangements must be made for appropriate coverage for individual's supervision.

30. Ensuring that the individual has the right to have reasonable visitations from family members and/or friends.

The following items are not commonly purchased for family use and may be purchased by the individual. The sponsoring agency Family Care Home Liaison must closely monitor the personal allowance expenditures during the required monthly visits to the Family Care home. If day services require that the individual brings a toothbrush or a razor, then day program funds the purchase of these items.

The individual should assume the cost of the following items:

1. Combs, hairbrushes, hair sprays, conditioners, oils, moisturizers.
2. Razors of any type including electric or disposable, pre-shave and aftershave lotion.
3. Any shampoo or soap that is specifically chosen by the individual because he or she does not wish to use that which is supplied by the Family Care provider.
4. Deodorant, sanitary napkins, lotions, perfume, nail polish, make up.
5. Toothbrushes, denture cleaner and cream.
6. Haircuts, perms, manicures, pedicures, facials.
7. Long distance telephone calls or a private line in their room if so desired.
8. Specialty cable services such as HBO if other persons in the household will not view it.
9. Lunches purchased in the individual's setting or employment if the individual so chooses.
10. Postage on their own correspondence.

June 1998	FAMILY CARE REFERENCE NYCRR PART 633 PROTECTION OF INDIVIDUAL RIGHTS	Policy 10.6.3

Each individual placed in a family care home is to be given the respect and dignity that is extended to others regardless of race, religion, national origin, creed, age, gender, ethnic background, sexual orientation, developmental disability, or other disability or health condition such as one tested for or diagnosed as having a Human immunodeficiency Virus (HIV infection). There must be no discrimination for these or any other reasons. In addition, no individual is to be denied:

1. Reasonable privacy.

2. The opportunity to receive visitors at reasonable times, and to have privacy when visited, provided such visits are not infringements on the rights of others.

3. The opportunity to socialize with members of the opposite sex, alone, or with others present, consistent with his or her socialization capability, under circumstances one would expect to find in a normal family living arrangement.

4. The opportunity to communicate freely with others outside the family care home, including reasonable access to a telephone.

5. The opportunity to correspond without restriction on incoming or outgoing letters or packages.

6. The right to perform only those chores or work activities, which are performed by other family members in the ordinary course of family living.

7. A safe and sanitary environment.

8. Freedom from physical, psychological, and verbal abuse.

9. Freedom from unnecessary use of mechanical restraining devices, unless medically prescribed.

10. Freedom from corporal punishment.

11. Freedom from unnecessary or excessive medication.

12. Nourishment.

13. Protection from commercial or other exploitation.

14. Freedom from being locked in a room.

15. A written Individualized Service Plan.

16. Confidentiality with regard to all information contained in the individual's record.

17. Appropriate, and humane health care, and the opportunity to have input, to the extent possible, either personally or through parent, guardian or advocate.

18. Observance and participation in the religion of his or her choice, through the means of his or her choice, including the right not to participate.

19. The opportunity to register, and vote and the opportunity to participate in activities that educates him or her in civic responsibilities.

20. The receipt of information, on or prior to admission to family care, regarding the supplies, and services that the home will provide, or for which additional changes will be made.

21. Access to clinically sound instructions on the topic of sexuality, and family planning services and information about the existence of these services including access to medication or devices to regulate conception, when clinically indicated (see *Policy 10.7.21-Premarital Counseling, Family Planning and Sexuality).*

22. The right to select his or her service coordinator and the right to participate in developing his or her Individualized Service Plan (ISP).

Confidentiality with regard to all information contained in the individual's record, is based on the requirements of Article 33 of the Mental Hygiene Law. A certified Family Care provider is allowed to receive certain information concerning the individuals in his or her home. It is required that the information that you are given or have acquired be kept confidential. This does not mean that an exchange of information between certified providers cannot take place when an individual moves from one home to another. However, any exchange of information concerning an individual in your home with another provider or anyone else outside of OMRDD or the sponsoring agency is a breach of confidentiality, unless the DDSO has authorized the exchange. A Family Care provider is authorized to share relevant information about the individual with the individual's health care practitioner. Providing second, hand information concerning an individual to another provider would also be considered a breach of confidentiality.

If, as a provider, you have acquired information concerning an individual living in Family Care, and you feel that this information should be given to the individual's current provider, it is important to involve the DDSO. A request must be made of appropriate DDSO staff to inform the provider of the information. If the information is factual, and the information is not considered to be "detrimental" to the individual, it is the obligation of the DDSO to give that information to the care provider.

FAMILY CARE
NOTIFICATION TO SPONSORING AGENCY STAFF OF SIGNIFICANT EVENTS IN AN INDIVIDUAL'S LIFE

June 1998 **Policy 10.6.4**

After taking whatever actions are appropriate to ensure the safety and well being of an individual, a Family Care provider is to immediately notify the sponsoring agency of any significant event in that individual's life and of any condition affecting the health and\or adjustment of the individual. There are certain situations, which are specified below, that may be of such a critical nature that the report cannot be delayed until the next day of business. In these situations, a *24-hour Crisis Telephone Number* is available for notification and/or to obtain further guidance. The Family Care Coordinator, Nurse, Medicaid Service Coordinator and/or Family Care Home Liaison will follow sponsoring agency policies and procedures to ensure notification and follow-up in such situations.

SITUATION REQUIRING NOTIFICATION	SPONSORING AGENCY STAFF MEMBER NOTIFIED
Serious Illness	Family Care Home Liaison and/or Nurse or 24-Hour Crisis Telephone Number
Need For Outside Emergency Care Medication Reaction	
Unexplained Absence of an individual from the Family Care Home: a) For individuals accustomed to independent movement in the community, this absence is reported as soon as an unusual departure from habitual schedule occurs. b) For individuals unable to care for themselves, this absence is reported immediately.	Family Care Home Liaison or 24-Hour Crisis Telephone Number
Death	Family Care Home Liaison 24-Hour Crisis Telephone Number
Increased Severity of Behavioral Problems	Family Care Home Liaison or 24-Hour Crisis Telephone Number

FAMILY CARE
NOTIFICATION TO SPONSORING AGENCY STAFF OF SIGNIFICANT EVENTS IN AN INDIVIDUAL'S LIFE

June 1998 | Policy 10.6.4

SITUATION REQUIRING NOTIFICATION	SPONSORING AGENCY STAFF MEMBER NOTIFIED
Personal Injury or Harm under circumstances where such injuries or harm may be deemed the responsibility of the Family Care provider, or members of the household or visitors to the Family Care home, the sponsoring agency, or any of its employees.	Family Care Home Liaison/Nurse or 24-Hour Crisis Telephone Number
Involvement in a criminal act, whether the individual has committed the act or is a victim of a crime.	Family Care Home Liaison/Nurse or 24-Hour Crisis Telephone Number
Medication Error such as administration of incorrect dosage or incorrect or unprescribed medication, failure to administer a prescribed medication; administration of medication to the wrong individual.	Medicaid Service Coordinator, Nurse/24-Hour Crisis Telephone Number
Property Damage by an individual under circumstances where such damage may be deemed the responsibility of the Family Care provider and/or the sponsoring agency, or any of its employees.	Family Care Home Liaison/Nurse
Behavior, negative or positive, which results from a significant event, including visits with relatives and friends.	Family Care Home Liaison/Nurse
Disruption of Activities or Treatment.	Family Care Home Liaison/Nurse or 24- Hour Crisis Telephone Number
Refusal of an Individual to Participate in Activities or Treatment.	

June 1998	FAMILY CARE STORAGE AND ADMINISTRATION OF MEDICATION	Policy 10.6.5

The Family Care provider is to assist an individual, as necessary, in the administration of medication. An individual who can self-administer medication independently, with supervision, or with assistance is to be encouraged to do so. Individuals who need supervision or assistance are to receive it. Sponsoring agency staff are to ensure provision of appropriate guidance, and instruction in the administration of medication to both the individual, and the Family Care provider through formal instruction and/or input from the prescribing physician and/or nursing staff.

If it is determined that an individual is not capable of independent self-administration of medication, a plan is to be developed by the team which will assist the individual to ultimately reach his or her optimum level of capability, unless the team determines that other program needs are of greater priority and are to be addressed first. Such a determination and the justification are to be detailed in the individual's service plan. When an individual has reached his or her optimum level of capability in relation to the self-administration of medication, documentation as to how and why this determination has been made must be included in the individual's plan of care.

All medications indicated by the label as controlled substances *must* be kept in a *locked* container which is accessible only to the Family Care provider; *all* other medications (prescribed and over-the-counter) kept in the Family Care home are to be stored in such a manner that they are not accessible at will to individuals or others residing in the Family Care home. The exception to this is, if an individual living in the Family Care home is capable of independent self-administration of medication, a controlled substance, syringes and needles must be stored in a locked area or container so as to be accessible only to the individual for whom it was prescribed. Under these circumstances the medication may be retained by that person in an individual, secured, storage area accessible only to the individual and the Family Care provider, unless it has been determined that such a procedure would jeopardize the safety of any other individual living in the Family Care home, or any other party.

There is to be separation of internal and external medication, either on separate shelves or separate storage units. Medication that must be stored in a refrigerator containing food must be placed in a locked container that is clearly marked to indicate that it contains medication. Medication is not to be stored in a container other than that which it was received. When a container is empty, it is to be disposed of immediately; it is not to be used for any other medications.

The sponsoring agency is responsible for ensuring that, at least annually, the capability of an individual and Family Care provider in the administration of medication is reviewed. The sponsoring agency is also responsible for monitoring the renewal, and/or review of prescriptions, as necessary.

The sponsoring agency has the responsibility to ensure that all medication purchased with an individual's personal funds must be used by or for that individual only. Over-the-counter medication is permitted when administered in accordance with the following:

1. Approval for a specific individual to use or be administered a medication is received in writing on no less than an annual basis.

2. There is information in the individual's record as to the condition for which a medication is to be used, the dosage frequency, and any specific instructions related to the medication.

3. The administration of over-the-counter medication does not exceed two days unless so specified by a practitioner. Exceptions are certain vitamins and over-the-counter medication that a practitioner instructs to be given on a daily basis.

4. If there is adverse reaction, a significant change in behavior, or any other significant indication(s) of a problem, the medication is to be suspended. The problem is to be reported immediately to the individual's primary physician and the DDSO staff.

All medication prescribed or disposed of must be in a manner that ensures the health, safety, and well being of the individual being served and in conformance with OMRDD's policies and procedures as well as applicable federal and state statute or regulations.

An individual has the right to be free from any unnecessary use of medications, and medication is not to be used for the convenience of staff or Family Care providers or as a substitute for day services.

The sponsoring agency must give special attention to those individuals receiving psychotropic medication to detect or prevent possible medical problems or side effects.

The Family Care provider, with assistance from sponsoring agency staff, must maintain a separate record for the administration of medication for each individual receiving medication. The record must specify, at a minimum, the individual's name, the name of the medication, the prescribing physician, the date ordered, the strength, the dosage form, the route, the frequency, the time, and the date of administration. The Family Care Home Liaison or a nurse ensures that medication records are reviewed monthly. A qualified medical professional is to review each individual's medication regimen at least quarterly.

Each individual's personal allowance must be used, and managed in accordance with the provisions of the Office of Mental Retardation and Developmental Disabilities (OMRDD) Personal Allowance regulations, 14NYCRR Parts 633.15; 633.99 and 635.9 of the Social Services Law set forth for recipients of Supplemental Security Income (SSI) in Family Care. Personal allowance must be used to reflect the individual's preferences and needs. Monies from personal allowance of several individuals may be commingled in an interest-bearing account through arrangements with the Social Security Administration.

The provider must provide for:

1. Adequate identification of the personal allowance belonging to each individual.

2. A secure place in the home and use reasonable care when funds are taken out of the home.

3. Equitable distribution of all interest to each individual's portion of the account.

4. Receipts to verify expenditure(s) of the individual's personal allowance.

If there is not enough money to cover the individual's personal allowance and the Family Care provider payment for room and board, the individual *MUST* be given the full personal allowance. The provider *MUST* contact the Family Care Coordinator

The Family Care provider will *NOT*:

1. Intentionally withhold an individual's personal allowance for any reason, including behavior management or punishment.

2. Demand, require or contract for all or any part of an individual's personal allowance to pay for operating expenses or supplies, and services, which the Family Care provider is mandated to provide.

3. Use an individual's personal allowance for any medical supplies or services for which payment is available under Medicaid, Medicare, and health insurance or through the sponsoring agency.

4. Use an individual's personal allowance for any items or supplies for which local, State or Federal funds are provided. This includes educational services mandated for children by the State Education Law.

5. Use an individual's personal allowance for restitution purposes for damages caused by that individual unless restitution is an integral part of the Individualized Service Plan (ISP), and is conformance with the following:

   a. The team has addressed the individual's behavioral needs.

   b. The team has determined that financial restitution is appropriate, and has meaning for the individual.

   c. The representative payee, if any, has provided written approval for the use of a portion of the personal allowance for such purposes.

   d. A committee, or part thereof, charged with protecting the rights of individuals in the sponsoring agency, has approved the time-limited use of that individual's personal allowance for such purposes.

6. Borrow from or pledge any personal allowance.

7. Co-mingle personal allowance funds with any funds belonging to the Family Care provider.

8. Use the individual's personal allowance to pay for a day program component such as teaching cooking every Friday or teaching basic hygiene. This is a day program's supply expense. It is, however, appropriate to use personal allowance if the individual's class goes on a trip and the individual as required to pay an activity fee. If the individual does not have adequate personal allowance funds, than the 809 funds may be used.

The Family Care provider must recognize that:

1. The individual's personal allowance must be used for his or her personal benefits based on his or her preferences and needs.

2. The expenditure of the personal allowance must involve the individual to the greatest extent possible.

3. Purchases made with personal allowance are the personal property of the individual, and the Family Care provider is responsible for ensuring respect for the individual's ownership of these items.

4. Personal Allowance can accumulate only if the individual does not have any unmet needs and the accumulation does not exceed the Supplemental Security Income (SSI) resource limits if the individual is a SSI recipient or the Medicaid resource limit if the individual is a Medicaid recipient or the individual is not a SSI recipient.

5. The Residential Habilitation Plan determines whether the individual is to be held responsible for any damages he or she caused.

Form AHR 171 State of New York PERSONAL ALLOWANCE LEDGER	Individual's Name

Family Care Provider: Date:

Date	Explanation	Deposits	Withdrawals	Balance	Verification

Revised October 1999

Individuals are to be encouraged to use their personal allowance to pursue individual interests, and/or fulfill personal needs. Thus, personal allowance ordinarily would be used to purchase items for exclusive use by a single individual.

When circumstances are such that an item is to be used routinely by a group of people over a period of time, the item may be obtained through group purchase in accordance with the requirements of the Social Security Administration (SSA). Where such a collective purchase is made, the provider must ensure that the amount contributed by each individual is approximately equal to the personal use or the advantage that individual is expected to gain from the purchase. The item purchased is expected to contribute to a more normal lifestyle for the individuals involved (14 NYCRR Section 633.15) (a) (8).

Effective November 1, 1996, Family Care providers can be reimbursed for transportation expenses when taking a Family Care individual to a Medicaid program or service, e.g., doctor, clinic, day treatment.

There are three categories of providers in the Family Care Program each with it's own mileage reimbursement procedure. The three provider categories are:

A. Agency-Sponsored Family Care Provider
B. State-Sponsored Family Care Provider
C. State and Agency-Sponsored Family Care Substitute Provider

The state-sponsored Family Care provider reimbursement claiming process is automated. The agency-sponsored Family Care provider, and state or agency-sponsored Family Care substitute provider reimbursement claims are manual claiming processes. The step-by-step claiming procedure for each is described in the attachments.

While there are separate claiming processes for each category of provider, the following Medicaid rules pertain to all.

1. Medicaid reimburses Family Care providers for transporting individuals to the following locations:

   Medical services:

   a. Physician's services
   b. Inpatient and outpatient hospital care
   c. Clinic services
   d. Dental services
   e. Physical or Occupational Therapy sessions
   f. Eye care
   g. Speech Pathology and/or Audiology services
   h. Trips to pharmacy

   Day programs:

   a. Day Treatment
   b. Day Habilitation and other Waiver services
   c. Other Medicaid day services, e.g., Medicaid funded Adult Medical Day Care, Office of Mental Health Continuing Day Treatment.

2. Mileage can be claimed both for transporting an individual to one of these locations and for the provider's return trip home after dropping the individual off. Mileage associated with the provider's return trip back to pick up the individual is also reimbursable. For example, mileage may be claimed for transporting the individual to day treatment, the provider's ride back home after drop-off, the provider's trip back to the day treatment for pick up, and finally for the trip home with the individual in the car.

3. Mileage to a hospital and back may be claimed when:

   a. the individual is to be admitted to or discharged from the hospital,

   b. the individual is to receive a service as an outpatient,

   c. the individual is in the hospital, and the doctor has requested the provider's presence at the hospital, or

   d. when it is necessary for the Family Care provider to go to the hospital to consult with hospital staff about the individual's medical care and services.

NOTE: A trip to the hospital for the purpose of visiting the individual is not Medicaid reimbursable transportation.

4. Travel expenses other than mileage are reimbursable, as well. For example, the costs of tolls, parking, public transportation and, under exceptional circumstances, taxi fare, may be claimed. Dated receipts should be attached to the claim form as verification of expense incurred.

5. Reimbursement is made for *vehicle miles* and associated expenses. The number of individuals transported in the vehicle is not a factor in reimbursement.

6. Claims for mileage reimbursement and for tolls and/or parking will be processed and paid only when the appropriate OMRDD form is completed in accordance with OMRDD requirements. Mileage reimbursement will be made at the rate approved for Family Care providers at the time the trip was made.

7. When a Taxi can be used:

The use of a taxi may be approved by the Family Care Coordinator or designee under the following exceptional circumstances only:

a. the Family Care provider does not have access to a vehicle at the time the trip needs to be made,

b. there is no transportation provided by the program or service that the Family Care individual is attending, or

c. no other means of transportation is available that is suitable for the Family Care individual's use.

If these circumstances pertain, a "Medicaid taxi" is typically used and the transporter bills Medicaid directly. *On an exception basis,* however, a Family Care provider may pay out of pocket for the taxi fare. The provider may submit a claim for reimbursement of the taxi fare using the procedure for submitting claims for Family Care transportation expenses.

FAMILY CARE
STATE AND ASFC SPONSORED CERTIFIED
PROVIDER MEDICAID TRANSPORTATION
REIMBURSEMENT PROCEDURE

December 2000 **OMR FORM 199** **Policy 10.6.9A**

The following Medicaid transportation claiming procedure applies to both state and ASFC sponsored certified Family Care providers.

RESPONSIBILITY		PROCEDURE
Family Care Coordinator or Designee	1.	Approves the use of the provider's personal vehicle to transport the individual living in the provider's home to an allowable Medicaid destination after exploring other appropriate means of transportation, e.g., community volunteer services, public transportation.
	NOTE:	If the Family Care Coordinator or designee has approved the use of a taxi to transport the individual to an allowable destination (see exceptional circumstances for taxi use in policy statement), and the provider has paid out of pocket for the taxi fare, the provider may claim for reimbursement using this procedure. Also, if the Family Care provider uses public transportation to take the individual to a Medicaid program or service, the Family Care provider may claim for reimbursement for the provider's fare, as well as, the individual's fare
	2.	Gives the Family Care provider a supply of the claim form OMR 199 titled "New York State Office of Mental Retardation and Developmental Disabilities Family Care

Provider Reimbursement for Consumer Transportation" and instructs the Family Care provider in form completion (instructions are on the back of Form OMR 199).

NOTE: A supply of OMR 199 forms can be ordered from the Utica Print Shop according to the DDSO business office's standard forms ordering procedures.

Family Care Provider

3. Drives the individual and notes mileage. Obtains receipts for tolls and/or parking expenses or public transportation if used. A receipt is also required for out of pocket taxi expenses.

4. Completes sections 1 through 14 of Form OMR 199 titled "New York State Office of Mental Retardation and Developmental Disabilities Family Care Provider Reimbursement for Consumer Transportation Form" according to instructions on the back. Signs and dates the form in Section 15. Forwards the white and yellow copy to the Family Care Coordinator or designee with all applicable receipts attached and keeps the pink copy.

NOTE: Item # 1 on Form OMR 199 labeled FC Program code is the Operating Certificate number of the Family Care home.

Item # 5 on Form OMR 199 labeled TABS ID# is the individual's Tracking and Billing System (TABS) identification number. This can be obtained from the DDSO Family Care Home Manager.

Item # 7 on Form OMR 199 is the trip destination. For Medicaid purposes, the name and title of the medical practitioner or the name of the facility and the address must be included.

For example:

a. A trip to the doctor's office, should be entered as:

   Doctor John Smith
   160 Eagle St.
   Albany, NY 12208

b. A trip to a clinic should be entered as:

   Albany Medical Center Outpatient Clinic
   75 New Scotland Avenue
   Albany, NY 12229

c. A trip to a day treatment program should be entered as:

   Rensselaer ARC Day DT Program
   Route 2 and 278, P.O. Box 7
   Cropsyville, NY 12075

Item # 8 on Form OMR 199 is the trip type. To comply with Medicaid rules, "MED" should be checked if the trip was to a Medicaid medical service, e.g., doctor, clinic, hospital, pharmacy. "DAY" should be checked if the trip was to a day treatment program or day habilitation program, waiver supported employment or waiver pre-vocational services, Medicaid funded Adult Medical Day Care, Office of Mental Health Continuing Day Treatment.

Family Care Coordinator or Designee

5. Within two weeks of receipt, reviews the completed Form OMR 199 to ensure:

   a. The trip(s) was an allowable Medicaid destination and the Family Care provider has included the name and title of the medical practitioner and the name of the facility and the address,

   b. the form is accurately completed, i.e., math is correct, TABS ID#s are correct, a certified Family Care provider has signed and dated the form, and

   c. necessary receipts are attached and receipts match service dates shown on the form.

6. Completes the Administrative Review Section 16 by checking either the "approved" or "not approved" box; prints name and title on the

		line labeled "Reviewed by"; enters TABS staff ID# (Non Applicable for ASFC); enters the sponsoring agency name, signs name on the "signature"line; enters date and phone number.
ASFC Coordinator	7.	Sends approved forms to DDSO designee with letter noting contact person (ref. From)
Family Care Coordinator or Designee	8.	Gives, if the OMR 199-claim form is approved, the original (white copy) to the data entry staff retains the yellow copy and any receipts that were attached. Returns, if the OMR 199 claim form is not approved, the form and any attached receipts to the Home Liaison who will contact the Family Care provider regarding the disapproved claim or to the ASFC contact person for ASFC providers.
Data Entry Staff	9.	Upon receipt of an approved OMR 199 claim form, enters the following items in TABS: Item # 1 - FC Program Code Item # 5 - TABS ID # Item # 8 - Trip Type Item # 9 - Date of Trip Item # 10 - Trip Miles Item # 12 - Other Costs Item # 16 - TABS Staff ID#

	10.	Verifies, upon entering Item # 10 - Trip Miles, that the dollar amount that is automatically calculated and displayed by the system on the entry screen agrees with the Family Care provider's completion of Item # 11- Dollar Amount on the OMR 199.
	11.	Draws, where the Family Care provider has made a calculation error, a line through the Dollar Amount in Item # 11 on the form and writes in the correct amount and continues with processing.
	12.	Notes, if the information as shown on the OMR 199 cannot be entered successfully in TABS, the problem on the form. Either calls the DDSO administrator who reviewed the form as indicated in Section 16 for clarification or if necessary, returns the form to the administrator noting the reason why the claim cannot be processed.
Family Care Coordinator or Designee	13.	Returns any forms that cannot be processed to the ASFC contact person.
Data Entry Staff	14.	Initials and dates, once all trip information is successfully data entered in TABS, the form in the space provided on the bottom right hand corner. Returns the form to the Family Care Coordinator or designee.
Family Care Coordinator or Designee	15.	Receives OMR 199 claim form from the data entry staff:

a. Retains, if OMR 199-claim form was processed successfully, and is initialed and dated by the data entry staff on bottom of form, the original white copy with receipts for the DDSO's provider file. Or sends the form to ASFC designee for ASFC providers. (Medicaid rules require that the paper claim be retained for a period of six years.)

b. Reviews, if OMR-199 form could not be processed, and therefore was not initialed and dated by data entry staff, the reason why, as noted on the form by the data entry staff, and either corrects and resubmits for data entry, contacting the Family Care provider as necessary, or gives the OMR 199 to the Home Manager to return to the Family Care provider.

16. Runs TABS' report of Family Care provider Medicaid transportation services for review and, as necessary, gives the Family Care provider and the ASFC contact person a copy of the provider's services paid.

Other transportation reports available in TABS include:

1. Activity Report AR 26. This option allows designated staff to print or display a listing of Medicaid trips taken by a certified provider.

2. Activity Report AR 27. This option allows designated staff to print or display a listing of Family Care provider transportation activities that have been submitted to the Office of the State Comptroller for payment.

ASFC FORM LETTER

ASFC Coordinator/or Designee
Address

DDSO Designee
Address

Dear _____:

Please find _____ OMR 199's attached for Medicaid Transportation processing.

Name	# of OMR 199's	Total $ Amount
Jane Jones	3	$18.56
Mike Smith	2	14.40
Sam Somebody	4	32.50

If you have any questions, please feel free to contact me at (555) 555-5555.

Sincerely,

Sally Smith
ASFC Coordinator/Designee

FAMILY CARE
STATE OR AGENCY SPONSORED SUBSTITUTE
PROVIDER REIMBURSEMENT FOR MEDICAID
Rev. August 2004 TRANSPORTATION OMR FORM 200 Policy 10.6.9B

The following Medicaid transportation claiming procedure applies to both State and Agency-Sponsored Family Care providers and substitute providers.

RESPONSIBILITY		PROCEDURE
Family Care Coordinator or Sponsoring Agency Designee	1.	Approves the use of the substitute provider personal vehicle to transport the individual to an allowable Medicaid destination after exploring other appropriate means of transportation, such as community volunteer services, public transportation.
	NOTE:	If the Family Care Coordinator or designee has approved the use of a taxi to transport the individual to an allowable destination (see policy statement for exceptional circumstances for taxi use), and the approved substitute provider has paid out-of-pocket for the taxi fare, the substitute provider may claim for reimbursement using this procedure. If the Family Care substitute provider uses public transportation to take the individual to a Medicaid program or service, the service may claim for the cost of the substitute provider's fare, as well as, the individual's fare.
	2.	Gives the OMRDD 200 form titled "New York State Office of Mental Retardation and Developmental Disabilities Substitute Provider Reimbursement for Family Care Medicaid Transportation" to the substitute provider.
	NOTE:	The OMR 200 form is available for ordering from the Utica Print Shop. The telephone number for the Utica Print Shop is (315) 797-0274.

Family Care Substitute Provider

3. Drives the individual and notes mileage. Obtains receipts for tolls, parking, or public transportation. A receipt is also required for out-of-pocket taxi expenses.

4. **Completes Item # 1 through 11** on the OMR Form 200 claim form according to the instructions on the back, signs and dates the form in item # 12. Forwards to the OMR 200 to the Family Care Coordinator or designee.

NOTE: **Item # 5** on Form OMR 200 is the trip destination. For Medicaid purposes, the name and title of the medical practitioner or the name of the facility and the address *must be included.* For example:

a. A trip to the doctor's office, should be entered as:

Doctor John Smith
160 Eagle St.
Albany, NY 12208

b. A trip to a clinic should be entered as:

Albany Medical Center Outpatient Clinic
75 New Scotland Avenue
Albany, NY 12229

c. A trip to a day habilitation program should be entered as:

Rensselaer ARC DT Program
Route 2 & 278, P.O. Box 7
Cropsyville, NY 12075

Item # 6 on OMR Form 200 is the trip type. To comply with Medicaid rules, "MED" should be checked if the trip was to a Medicaid medical service, e.g., doctor, clinic, hospital, pharmacy. "DAY" should be checked if the trip was to a day treatment program or day habilitation program, *waiver* supported employment or waiver pre-vocational services, Medicaid funded Adult Medical Day Care, or Office of Mental Health Continuing Day Treatment program.

Family Care Coordinator or Sponsoring Agency Designee

5. Completes the administrative review of the OMR 200 form to ensure:

a. the person submitting the claim is an approved substitute provider,

b. the trip(s) was to an allowable Medicaid destination and the substitute provider has included the name and title of the Medicaid practitioner and/or the name of the facility and the address,

c. the form is accurately completed, the substitute provider has signed and dated the form, and

		d. the necessary receipts are attached and receipt dates match service dates shown on the form.
Family Care Coordinator or Sponsoring Agency Designee	6.	Follows procedures defined by DDSO for processing of the payment.
Family Care Coordinator or DDSO Designee	7.	Sends DDSO Family Care Coordinator or designee the completed original (white copy only) form to: 44 Holland Avenue Albany, New York 12206, if approved. The DDSO retains the yellow copy, and gives the pink copy to the provider.
OMRDD Prior Approval Unit 44 Holland Avenue, Albany	8.	Processes claim form for payment, within two weeks of receipt of the approved OMR 200.

	FAMILY CARE **REIMBURSEMENT FOR TRAVEL** **RELATED TO THE INDIVIDUALS**	
Rev. August 2004	**RESIDENTIAL HABILITATION PLAN**	**Policy 10.6.10**

Family Care providers, who are enrolled in the Critical Driver Program, may request automobile mileage reimbursement from the sponsoring agency when transportation is provided for an individual living in their home if the activity is documented in the individual's Residential Habilitation Plan or Individualized Service Plan. The activity must be unique to that individual and is not considered an activity of the family.

It is the expectation that each Family Care provider includes the individual(s) living in their home in the typical activities of a family/household. Reimbursement is, therefore, not available for routine shopping outings, recreational activities such as bowling or attending a movie, going to the supermarket, going to restaurants, day trips such as visiting the local museum, going to garage sales on week-ends, going to flea markets, taking a ride or visiting relatives or friends of the provider.

This reimbursement is allowed where:

1. It is necessary to transport an individual to activities identified by the Individual Service Plan (ISP)/Residential Habilitation Plan. These activities include but are not limited to the following:

    a. Non-Medicaid day services or employment or seniors programs.

    b. Educational programs (adults only).

    c. Community recreational programs, or evening activity sponsored by the sponsoring agency, attended by the individual.

    d. Evening activity sponsored by the day program such as a dance.

    e. Attending a "learn to swim" program.

    f. Transporting the individual to visit the individual's relative or friend.

    g. Other non-individual specific travel to include attendance at: the Family Care Advisory Council meetings, training being held by the sponsoring agency or training at the request of the sponsoring agency.

    h. The individual is hospitalized and the provider visits the individual at the request of the hospital or at the request of the sponsoring agency staff.

2. There is no other suitable means of transportation available.

3. The Family Care provider uses a private vehicle to take the individual to these activities.

Note: For the procedure on Family Care provider reimbursement for transportation to Medicaid programs or services see Policy 10.6.9.

Reimbursable transportation expenses include mileage, tolls and parking. Reimbursement for mileage will be made at the current State reimbursement rate. Reimbursement will be made on a per trip rather than on an individual basis, i.e., if two or more individuals are transported at the same time, reimbursement for travel expenses will be made for one trip only.

Travel beyond 50 miles, one way, requires the prior approval of the sponsoring agency Family Care Coordinator or other appropriate sponsoring agency staff. The following procedure on mileage reimbursement also applies to a substitute provider or volunteer approved by the local sponsoring agency when using a private vehicle to transport a Family Care individual to an activity (see 1 above for allowable destinations).

RESPONSIBILITY	PROCEDURE
Family Care Home Liaison/ Medicaid Service Coordinator	1. With the Family Care provider, determines transportation needs of the individual to meet program requirements as identified in the Individualized Service Plan (ISP).
	2. Approves the general use of a private vehicle by the Family Care provider, volunteer, or substitute provider to transport the individual to program.

Prior to the Family Care provider seeking transportation reimbursement on behalf of an individual living in the home, the provider, the Family Care Home Liaison, and the Medicaid Service Coordinator should reach an understanding as to the activities that are eligible for reimbursement after a determination is made that there are no alternate means of transportation.

NOTE: Trips more than 50 miles one way require special approval by the Family Care Coordinator or other appropriate sponsoring agency staff. Where approval is denied, the Family Care Coordinator or other sponsoring agency staff notifies the provider in writing with a copy to the Family Care Home Liaison and Medicaid Service Coordinator, that other transportation options must be explored.

Family Care Coordinator or Appropriate Sponsoring Agency Staff	3.	Supplies the provider with the claim forms, i.e., AC-132 Travel Voucher, AC-148 Continuation Sheet and the AC-160 State of Automobile Travel and instructs the provider in forms' completion (see sample forms in Addendum A, and C). ASFC providers may use form designated by sponsoring agency.
Family Care Provider/ Substitute Provider/DDSO Approved Volunteer	4.	Drives the Family Care individual to the activity/program(s) and, where appropriate, obtains receipts for tolls and/or parking.
	5.	Completes travel voucher forms and submits with receipts for tolls and/or parking, where appropriate, to the designated sponsoring agency staff within 60 days of travel date.
	NOTE:	Claims submitted by the Family Care Provider must include documentation of mileage that exceeds the $10 per month, per person allotment included in the Difficulty of Care (DOC) payment. For example, 3 individuals in the home -$30.
Family Care Coordinator Or Designee	6.	Reviews the completed travel voucher forms (and in the case of claims submitted by the Family Care provider, reviews documentation showing that the $10 allotments were met). If approved, signs and forwards to the sponsoring agency Business Office.

Sponsoring Agency Business Office	7.	Processes the travel voucher claim form for payment and ensures that records of expenditures are maintained to facilitate inclusion of expenditures in required Family Care budget reports.

In the event that a Family Care provider lost or is missing a Medicaid Transportation Check paid through the automated process, the DDSO staff is responsible for:

1. Verifying that a check has been issued to the provider utilizing the Medicaid Transportation Payment Report.

2. Completing a "Lost/Missing Check Request for Automated Medicaid Transportation Payments" (see attached form).

3. Sending the Request to the designated person at Revenue Support, OMRDD, 44 Holland Avenue, Albany, New York 12229

If the missing check has been returned to the Department of Taxation and Finance, it will be sent directly to the Family Care provider utilizing the mailing address provided on the Lost/Missing Check Form.

If the check has not been returned to the Department of Taxation and Finance, a STOP PAYMENT will be processed immediately. This process will generate an APPLICATION FOR ISSUANCE OF A DUPLICATE CHECK. The application, with instructions, will be forwarded directly to the DDSO contact person. The DDSO is responsible for ensuring that the application is given to the Family Care provider. The DDSO contact person will return the completed application to Central Office staff. The application will produce a duplicate check, which will be mailed to the DDSO contact person. If the missing check has been cashed, a copy of the canceled check will be sent to the DDSO contact person by Central Office staff. If after reviewing the signature, the provider (s) indicates that it is not his or her signature, the DDSO contact person MUST notify Central Office staff to obtain a "Forgery Affidavit." The DDSO contact person is responsible for ensuring that the Family Care provider signs the Affidavit and has it notarized. The Affidavit MUST be returned to Central Office staff for issuance of a new check. Providers MUST be informed that obtaining a duplicate check can take several weeks.

Family Care lost/Missing Check Request
For Automated Medicaid Transportation Payments

DDSO _____ State Sponsored ( ) Agency Sponsored ( )

Contact Person _____ Title _____

Telephone # _____

Provider Name _____

Provider Mailing Address _____

Payment Report Date _____ Amount of Check _____

Voucher # _____

(A Copy of the FC Transportation Report with the provider's name MUST accompany this report).

Explanation

_____

_____

_____

_____

_____

_____

_____
Print Name Family Care Coordinator or Other DDSO Staff Date

_____
Signature Family Care Coordinator or Other DDSO Staff Date

SECTION 10.7

SERVICES TO INDIVIDUALS LIVING IN FAMILY CARE

10.7.1 The Team

10.7.2 Family Care Coordinator (FCC)

10.7.3 Medicaid Service Coordinator(MSC)

10.7.4 Family Care Home Liaison (FCHL)

10.7.5 Qualified Mental Retardation Professional (QMRP)

10.7.6 Nursing Services

10.7.7 Psychological Assessment

10.7.8 Social Assessment

10.7.9 Activities

10.7.10 Review and Discussion of Recreational Needs and Activities

10.7.11 Recreational Trips

10.7.12 Design and Implementation of the Individualized Service Plan (ISP)

10.7.13 Maintenance of the Individualized Service Plan and Distribution to the Family Care Provider

10.7.13A Early Intervention Program for Infants and Toddlers, Ages 0-3

10.7.14 Objection to and Appeal of the Individualized Service Plan (ISP)

10.7.15 Objection to and Appeal of Care and Treatment

10.7.16 School Notification Process for School Age Children Who Move into a Family Care Home.

10.7.17 Individualize Education Program

10.7.18 Clothing and Personal Supplies for Individuals Moving into Family Care

10.7.19 Maintenance of Clothing and Personal Supplies Inventory for Individuals in Family Care

10.7.20 Emergency and Transitional Moves: Time – Limited Services Elsewhere

10.7.21 Premarital Counseling, Family Planning and Sexuality

10.7.22 Legal Guardianship

Each individual must have access to professional staff representing those primary service providers, professions, disciplines, and other parties interested in the individual's welfare. It is the responsibility of the Medicaid Service Coordinator to work with the professional staff, the individual, and his or her advocate to:

1. Identify needs based on appropriate evaluations/assessments.

2. Participate in developing a comprehensive Individualized Service Plan (ISP) based on the individual's personal needs, goals, and preferences.

3. Provide that programs, services, activities, and supports in both the Family Care home and day services are compatible, and are being provided in accordance with the ISP, Residential Habilitation Plan, and Day Habilitation Plan, if appropriate.

4. Review with the team, at least semi-annually, the Individualized Service Plan (ISP) in response to the individual's changing needs, and make necessary recommendations to change the ISP.

5. Provide, in conjunction with the Family Care Home Liaison, that the current Family Care home is appropriate to meet the individual's needs.

The team may include:

1. The Family Care Provider.

2. The individual.

3. Family Care Home Liaison.

4. Medicaid Service Coordinator.

5. A representative of medical/health services.

6. Those individuals who represent primary services relevant to meeting the needs of the individual.

7. A representative of day or education services.

8. The individual's advocate and/or family member.

A Qualified Mental Retardation Professional (QMRP), by whatever title known, designated by the sponsoring agency as having administrative and/or liaison responsibility for the agency's Family Care Program. This staff may act as liaison between the DDSO - Sponsored Family Care Program, the Voluntary Agency - Sponsored Family Care Program (ASFC), Central Office Family Care Unit, and other applicable service organizations with relation to the Family Care Program. This staff person or his or her designee may also serve as a central entry point where Family Care providers can raise concerns and issues regarding services to the individuals or issues impacting the family.

Responsibility of the Family Care Coordinator (FCC):

1. Ensuring compliance with written policies and procedures relative to obtaining, reviewing, evaluating, and verifying the background of, and information provided by applicants on *LS 22 Application for Family Care Home Certification.*

2. Ensuring that providers receive copies of all regulations, a copy of the Family Care Manual, any updated policies, an original copy of the operating certificate, and other information pertinent to the Family Care Program, as well as satisfying all requirements for training, physical plant, fire, safety, the State Central Registry and the Department of Criminal Justice Services (DCJS).

3. Ensuring that the Family Care Home Liaison home visits the Family Care on a monthly basis, visits are documented on Form 239 and reviewed by supervisory staff. Ensuring, as required by 14 NYCRR Part 687, that at least two (2) inspections are made during each calendar year, and one must be without notice using Form 238.

4. Ensuring a quarterly nursing visit to the Family Care home.

5. Ensuring that written recommendations are provided to non-Family Care certification staff on initial certification and on homes being evaluated for recertification.

6. Ensuring the timely recertification of all existing Family Care homes and provide recertification packet to certification staff.

7. Ensuring that the Family Care Advisory Council meets on at least a quarterly basis, and that minutes are recorded, and distributed, in a timely manner, to attendees, and appropriate central office staff. Ensuring that all issues, concerns and

recommendations are addressed. Preparing or assisting in the preparation of the agenda for the council meeting, as well as, notifying Central Office Family Care Unit of scheduled meetings of the Council. (Ref. Family Care Policy 10.1.3)

8. Ensuring that a current record is maintained for each Family Care provider. The Family Care Coordinator must ensure that the record is accurate and updated as needed.

9. Ensuring the timely entering of Family Care providers' certification, and recertification data into the Tracking and Billing System (TABS).

10. Ensuring that each individual living in Family Care has obtained a non-driver photo-identification card from the Department of Motor Vehicle or other governmental entities.

11. Ensuring the investigation of all incidents, and/or allegations of abuse, and neglect consistent with 14 NYCRR Part 624 Reportable Incidents, Serious Reportable Incidents and Abuse. (Ref. Family Care Policy 10.1.14)

12. Monitoring, and approving all payments made to providers, or investigating inquiries regarding late and missing checks. Ensuring that appropriate staff receives a copy of the Difficulty of Care Payment (DOC), and Error Reports, the FCCA Clothing and Error Reports, Family Care Transportation Payments and Error Reports.

13. Working with the DDSO Business Office to ensure that payments for home modifications, provider, and other reimbursements are made in a timely manner.

14. Ensuring that the monthly DDSO Family Care census is accurate, and all corrections are entered into the Tracking and Billing System (TABS) in a timely manner including addresses and Social Security numbers.

15. Ensuring that each prospective Family Care provider receives thirty hours of training prior to issuance of the operating certificate.

16. Ensuring that each Family Care provider receives on going training as required and training based on the specialized needs of the individual or needs of the provider.

17. Monitoring, and approving, trial visits, substitute provider services and therapeutic leave.

18. Ensuring that the Residential Habilitation Plan is updated is needed and is focused on the positive aspects of the individual, as well as, identifying specific behavioral, and/or medical needs, and concerns.

19. Ensuring that the goals, objectives, outcomes, and preferences of the individual as outlined in the Residential Habilitation Plan are being carried out, and ensuring the collaboration of interested parties to make any necessary modifications to the Residential Habilitation Plan.

20. Monitoring as appropriate with the sponsoring agency the spending of the Family Care Appropriations.

21. Monitoring with the DDSO business officer, expenditures and the spending plan for Family Care, and maintaining a current roster of Personal Care/Grandfathered Variable Rate and Exceptional Circumstance individuals.

22. Working with appropriate sponsoring agency and central office staff to provide input for the Family Care budget.

23. Ensuring that procedures are followed when the operating certificate is limited, temporarily suspended, revoked or terminated, and, in conjunction with the Family Care Home Liaison, notifying the provider of the status of the proceedings, and ensuring due process for decertification or limitations placed on the operating certificate.

24. Serving as liaison with the Office of Counsel for temporary suspension of operating certificates, home closures, application denials, and hearings.

25. Ensuring that potential and certified providers are informed of their rights pertaining to an OMRDD license to sponsor a Family Care home.

26. Confirming or ensuring that Medicaid Service Coordinators selected outside the OMRDD system has basic understanding of the Family Care Program.

27. Ensuring that Family Care Home Liaisons have been trained and have knowledge of the administration and program requirements of the Family Care Program.

28. Planning an annual recognition activity for Family Care providers at a place convenient for providers.

29. Providing training, as needed, to Family Care Home Liaison staff to ensure that staff are knowledgeable of current regulations and policies and that all staff are consistently following policy.

30. Providing information and/or assistance to central office staff regarding policies, requests for information, etc.

Definition:

Medicaid Service Coordinators (MSC) help people explore what they want and need in life, and then assist them in getting it. They work in partnership with the person and/or family to develop, implement, and maintain the person's life plan. This life plan describes who the person is, his or her strengths, capabilities, needs and valued outcomes, and the supports and services he or she wants to achieve these outcomes. Medicaid Service Coordinators assist people to attain the highest quality of life and live as independently and productively as possible.

Skills and Abilities:

A Medicaid Service Coordinator must possess many skills and abilities in order to provide quality service. These include but are not limited to:

1. Understanding person centered planning, individual directive services, and self-advocacy.
2. Listening carefully to what people and families are saying.
3. Recognizing and addressing health and safety issues.
4. Facilitating meetings.
5. Communicating (verbally and in writing) with individuals, families, advocates, and providers.
6. Knowing about services and supports (both traditional OMRDD funded and community based resources).
7. Resolving crisis situations.
8. Negotiating and resolving conflicts.
9. Accessing entitlements and benefits.
10. Advocating for people.

11. Ensuring the quality of the person's living environment.

12. Maintaining an up-to-date life plan for the person, and

13. Keeping a written record.

Responsibilities:

Most of the activities of a Medicaid Service Coordinator fall into three general categories:

1. individualized service planning,
2. advocating, and
3. record keeping.

Individualized Service Planning

The first critical role places the focus of all planning activities on the needs and desires of the individual with developmental disabilities or mental retardation. These activities bring together people who the person feels are the most important in his or her life to help develop a plan to meet the person's goals and to help him or her live a life they want. Individual service planning is now often referred to as A Person Centered Planning (ref. OMRDD *Vendor Medicaid Service Coordination Manual*, September 2002, page 1, Appendix One).

Advocating

Another critical role of the MSC is advocating. Most of the activities performed by a MSC on a daily basis have some element of advocacy associated with them. Two groups of activities that are especially critical deal with protecting and upholding the individual's rights, and ensuring that the individual's living environment is safe.

Protecting and upholding the individual's rights include intervening when the individual feels his or her rights are being denied.

Record Keeping

The third category focuses on keeping accurate and current records on service coordination activities and other services provided to the individual. The documents and notes within the individual's service coordination record provide a chronological, ongoing written record of relevant information about the individual and his or her life that helps a service coordinator provide person centered, quality services.

Medicaid Service Coordinator

1. Develops the Individualized Service Plan (ISP).

    a. Uses person centered planning to identify the individual's desired outcomes and those supports and services the individual wants and needs.
    b. Develops the Preliminary ISP (for people enrolled in the HCBS waiver).
    c. Develops ISP and Service Coordination Agreement for all MSC enrollees.

2. Implements the individual's ISP.

    a. Coordinates the access and delivery of supports and services chosen in the ISP.
    b. Locates or creates natural supports and community resources.
    c. Locates funded services, helps determine eligibility, completes referrals, facilitates visits and interviews.
    d. Ensures essential information is made available to providers and others with the appropriate consent of the individual.

3. Maintains the ISP.

    a. Uses a person centered planning process to review the ISP and Service Coordination Agreement at least every six months and makes necessary revisions to ensure these documents are up-to-date.
    b. Ensures that all supports and services being provided are consistent with the individual's needs and goals.

4. Conducts monthly face-to-face meeting with the individual and visits the individual in his or her Family Care home on at least a quarterly basis.

5. Works with the individual who wants to change the Medicaid Service Coordination (MSC) Vendor.

6. Works with the individual who wants to withdraw from MSC.

7. Works with HCBS Waiver participants who withdraw from MSC to identify a Plan of Care Support Services provider.

8. Assists the individual in completing the Consumer Application for Participation in MSC.

9. Ensures that the individual is healthy and safety needs are met, and his or her residence is appropriate.

10. Reports any significant unmet or safety needs in the Family Care home by:

    a. Complying with NYCRR Part 624.
    b. Using the Service Coordination Observation Report (MSC7-SCOR).
    c. Documenting in the ISP that safeguards are in place to protect the individual's health and safety needs.

11. Advocates for the individual by:

    a. Intervening when the individual is experiencing problems with his or her living arrangement such as an eviction.
    b. Ensuring that the individual's living environment is safe.
    c. Obtaining information about the quality of services.
    d. Ensuring the person is satisfied with the review and supports being received.

12. Maintains required MSC records (ref. Vendor MSC Manual).

13. Ensures the individual's Medicaid eligibility is maintained.

14. Ensures that the individual's required HCBS Waiver eligibility is maintained by ensuring:

    a. Annual Level of Care Determination is completed.
    b. Individual's participation in at least one HCBS Waiver service each year.

15. Maintains monthly case notes.

16. Records the ISP, Service Coordination Agreement and monthly notes.

17. Maintains a separate record of each individual receiving MSC. The record is known as the Service Coordination record which consists of four sections (Section 1-Eligibility/Enrollment Documentation. Section II-Written Evaluations. Section III-ISP with attachments, and Section IV-Service Coordinator Monthly Notes).

18. Develops in conjunction with the individual, Family Care Home Liaison, provider and advocate, the Personal Expenditure Plan (PEP).

The Medicaid Service Coordinator must meet all of the following minimum educational, experiential and training requirements:

Minimum Educational Level

An Associate's degree in a health and human service field, or an RN.

NOTE: A candidate for a bachelor's degree may meet this educational requirement by providing a letter from his or her college verifying that the candidate has completed course work equivalent to an Associate's degree both in total number of credits received and number of credits earned in a health or human service field.

Minimum Experiential Level

One year experience working with individuals with a development disability, or

One-year experience as a Medicaid Service Coordinator with any population.

NOTE: The minimum experiential level requirement *does not* have to be met if the person has a master's degree in a health or human service field.

Minimum Training Level

Attendance at an OMRDD- approved Core Service Coordination training program within three months of assuming MSC supervisory responsibilities, unless the person can produce certificate verifying past attendance at a Core Training.

A copy of the Medicaid Service Coordinator's Core certificate must be kept on file and be available for OMRDDs staff review.

In addition to Core training, Medicaid Service Coordinators must attend fifteen (15) hours of professional development annually. This professional development may include lectures, workshops, and other training sessions conducted by OMRDD, other agencies, educational institutions, or generic community organizations.

Required and Recommended Professional Development

OMRDD has identified six professional development programs that are essential to the enhancement of service coordination skills. Medicaid Service Coordinators are required to attend four of these six programs within *two years* of their employment as an MSC. These professional development programs are:

1. Waiver Services
2. Introduction to Person Centered Planning
3. The Individualized Service Plan (ISP)
4. Self Advocacy and Self Determination
5. Benefits and Entitlements
6. Quality Assurance

Definition:

The Family Care Home Liaison is that staff person who has primary responsibilities for ensuring that all program and any environmental requirements related to the Family Care home are being met and maintained. This staff person also ensures that fiscal and other provider needs and concerns are addressed and are met consistent with the needs of the individual(s) in the home. This staff acts as a direct link between the Family Care provider and the sponsoring agency (Ref. Mallory, *State and Voluntary Sponsored Family Care Training for Family Care Home Liaisons, Medicaid Service Coordinators, Certification Staff and Family Care Providers,* OMRDD, Revised August 2004).

Skills and Abilities:

This staff person:

1. Must have a working knowledge of the Family Care Program to include but is not limited to a working knowledge of:

   a. *New York Codes Rules and Regulations* (NYCRR) Part 635 General Quality Control and Administrative Requirements Applicable to Programs, Services and Facilities Funded or Certified by the OMRDD.

   b. Part 633 Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OMRDD.

   c. Part 624 Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated and/or Certified by OMRDD.

   d. Part 687 Family Care Homes For The Developmentally Disabled.

   e. Article 33§16 of the Mental Hygiene Law Access to Clinical Records.

   f. The Home and Community Based Services waiver.

2. Must have an understanding of the *Family Care Policy Manual*, as well as an understanding of the role and responsibilities of the Medicaid Service Coordinator (MSC) in the Family Care Home.

3. Must possess good interpersonal skills, good oral and written communication skills as well as good listening skills.

4. Must understand the concept of confidentiality and understand and be capable of dealing with diverse personalities, ethnic and religious situations.

5. Must ensure, through observation during the monthly home visits and by using Form 239, that each member of the family accepts the individual, and that the individual's rights are not being violated.

6. Must possess intuitive skills that will help him or her to know what is "going on" in the family.

7. Must be able to balance their responsibility to ensure the safety of the individuals while working with the Family Care provider to resolve issues/concerns that will further assist the provider in meeting the needs of the family and individual(s).

8. Must be able to intervene when there are unresolved issues between the Family Care provider and individual or a family member and the individual.

9. Must be capable of advocating for Family Care providers in terms of additional substitute services or justifying the need for additional funding under special circumstances based on the expressed needs of the individual.

10. Must be able to evaluate the Family Care provider's skills and abilities and have knowledge enough to know if the provider should be recertified to continue to provide services to persons with developmental disabilities, or should limitations be placed on the operating certificate.

11. Must be able to communicate to the Family Care Coordinator on any issues within the Family Care home that may compromise the operation of the home.

Responsibilities:

As the staff person assigned to the home, the FCHL must be prepared to provide support during a crisis in the family (death of a provider's family member, death of the individual or a serious illness of the provider, individual or provider's immediate family). The FCHL should understand what the family is experiencing and be aware of services within the community to recommend to the Family Care provider, if necessary.

On at least a quarterly basis, (every six months for individuals enrolled in the P.O.C.S.S.) the Family Care Home Liaison and the Medicaid Service Coordinator (MSC) should visit the Family Care home together. During the visit the MSC completes Form MSC 7-SCOR

Service Coordination Observation Report, and the FCHL completes *Form 239 Monthly Checklist.* A thorough walk through of the entire home must be conducted.

The Family Care Home Liaison (FCHL):

1. Enhances and maintains social functioning of Family Care providers as well as the individuals living in the home.

2. Confirms that program and any environmental requirements are being met and maintained.

3. Ensures that fiscal and other provider needs and concerns are addressed and are met consistent with the needs of the individual(s) in the home.

4. Acts as a direct link and contact for the Family Care provider to the sponsoring agency.

5. Conducts monthly home visits using Form 239:

   a. Confirms that the Family Care provider has current copies of the NYCRR regulations governing Family Care and that the provider understands the Family Care Program and the responsibilities of a Family Care provider (ref. Family Care Policy 10.6.2).

   b. Monitors the home as mandated by NYCRR Regulations and OMRDDs Family Care Manual.

   c. Ensures that the Family Care provider receives revised sections of the *Family Care Manual.*

6. Develops the Residential Habilitation Plan of Care with the Family Care provider and the individual consistent with the Individualized Service Plan (ISP).

   a. Reviews, on a monthly basis, or more frequently if necessary, the Residential Habilitation Plan of Care with the Family Care provider, and verifies that services were rendered by signing Form FC-DOC-4 "Statement of Affirmation for Provision of Family Care Residential Habilitation Services (ref. Policy 10.8.1 Family Care Manual).

   b. Ensures that the provider:

      i. Receives the original copy of the Residential Habilitation Plan.

      ii. Understands the Residential Habilitation Plan.

iii. Is willing and is capable of providing the services as identified in the Residential Habilitation Plan.

iv. Understands that the goals are specific to the needs and preferences of the individual, and that the valued outcomes are reasonable.

v. Understands the importance of completing the Statement of Affirmation for the Provision of Family Care Residential Habilitation Services or current form be used by OMRDD – ref. *Family Care Manual,* Policy 10.8.1.

vi. Understands the importance of the 22-Day Rule and its impact on payment if the individual is out of the home or services are not delivered – ref. *Family Care Manual* Policy 10.8.1.

vii. Understands the impact on the Difficulty of Care payment if the individual is hospitalized for a portion of the month or admitted to Intermediate Care Facility (ICF) or Health Related Facility (HRF) or Skilled Nursing Facility (SNF).

viii. Understands the procedure to take the individual on a trip exceeding 30 days and the necessity of a written agreement to be in place with an agency or professional in the field of Mental Retardation and Developmental Disabilities. The Family Care provider must obtain and reimburse the agency/professional staff for services rendered (ref. Family Care Policy 10.8.1).

ix. Participates in the semi and annual ISP review with the Medicaid Service Coordinator, individual, where appropriate and other interested parties.

c. Updates, with the participation of the Family Care provider, the completion of the biennium Developmental Disabilities Profile 2 (DDP-2).

7. Ensures, through a discussion with the Family Care provider that the family composition and income have not changed since the last visit.

8. Ensures environmental and safety requirements are met in conformance with the Family Care Manual and the New York Codes Rules and Regulations (NYCRR) governing the Family Care Program.

a. Assesses and informs appropriate staff of any environmental changes in the home including structural, safety or changes in family composition that may impact on the person's life such as separation, divorce, loss of income.

b. Conducts a walk through of the entire home to ensure that the individual's sleeping arrangement has not been changed since the last home visit; the individual's personal possessions are accessible; evidence that each individual has adequate and individually owned personal hygiene supplies, as well as grooming and hygiene supplies customarily shared by a family; if present, firearms are secured in a locked cabinet.

   Ensures that the provider supplies the individual with adequate supply of linen; appropriate bedroom furniture to include bed and bed frame, mattress and box spring, chest of drawers, and dressers, chair and lamp or lighting.

c. Assesses the environment to ensure that the home is clean and neat, and free of hazardous conditions such as: trip hazards (torn linoleum, torn carpet), clutter (old newspaper, boxes, furniture), peeling paint, loose handrails.

d. Assists with and reviews the fire evacuation plan on no less then a quarterly basis. Ensures that fire drills are conducted monthly as well as observe at least one fire drill during the calendar year to ensure that each person (including members of the provider's family and the impact of any visitor's, especially young children or elderly relatives during the evacuation process) evacuates the home in a timely manner. Observes that there are no obstructions that will impact on the family's ability to exit the home.

e. Ensures by review of documents, that all dogs and cats residing in the home are properly immunized according to State requirements. Dogs must be licensed annually. Also ensuring that pets visiting the home are free from diseases and pose no threat to the individual(s) living in the home.

f. Prepares the plan of corrective action and ensures that the Family Care provider receives a copy as well as confirming that all deficiencies are completed in a timely manner.

g. Ensures that due process proceedings are followed when an operating certificate is suspended or revoked.

h. Collaborates with other staff as appropriate to safety and welfare of the individual(s) in the home.

i. Ensures that recertification of the home is completed in a timely manner by reviewing the previous six month of *Form 239 Family Care Checklist* and the last *Form 238 Family Care Home Evaluation and Survey* and submits to DDSO Non-Family Care Certification Staff or Quality Assurance a narrative with recommendations.

9. Ensures that all adults living in the home have been checked through the State Central Register and finger printed through the Division of Criminal Justice Services.

10. Ensures that the Family Care provider receives all payments and benefits in a timely manner as well as assists the provider in completing all necessary forms related to payments.

    a. Ensures that the provider is made aware of any changes in payments or benefits received on behalf of the individual.

    b. Monitors Difficulty of Care (DOC) payments and has a working knowledge of how DOC payments are calculated (ref. Family Care Manual Policy 10.8.1). (All reports are available through the Tracking and Billing System (TABS).

    c. Ensures that the Family Care provider fully understands the use of Personal Allowance, and has read and has a working knowledge of NYCRR Part 633.15 governing the Use of Personal Allowance.

    d. Ensures that there is documentation of all expenditures on behalf of the individual and receipts are secured, as necessary.

    e. Monitors, where necessary with appropriate staff, the availability of adequate clothing and completes a clothing assessment prior to the distribution of the clothing funds issued twice a year.

    f. Assists in completing the provider portion of the Family Care Home Loan Application – ref. Family Care Manual-Policy 10.11.1.

    g. Arranges, in conjunction with the Medicaid Service Coordinator, trial visits to the Family Care home and assists in processing appropriate documentation to ensure timely payment. Also ensures that the individual has spending money during the trial visit in conformance with ref. Family Care Policy 10.8.10.

    h. Ensures that each individual living in Family Care has a Personal Expenditure Plan (PEP) that has been developed with the Family Care provider and interested parties, and the PEP is reviewed and revised to reflect updated priorities.

    i. Ensures that cash -on-hand per individual does not exceed the amount outlined in regulations.

11. Ensures that each Family Care provider receives a cumulative of 24 hours of training at the time the home is recertified.

12. Ensures that all significant events or situations that may endanger the well being of individuals are promptly reported, reviewed, investigated and corrective actions taken as necessary.

13. Ensures that each Family Care provider has access to an approved substitute provider or sitter who is available to provide short-term substitute services when the provider is in need of relief or is absent from the home. Ref. *Family Care Policy 10.4.4.*

14. Maintains or ensures the maintaining of a record on each Family Care home to include but is not limited to: documentation on certification and recertification; LS 22 *Application for Family Care Home Certification*; three letters of references; medical statement; documentation on 30 hours of required initial training as well as (FC-13T) 24 hours of required on-going training prior to being recertified; State Central Register; Forms 239 Monthly Checklist; Form 238 Family Care Home Survey and Evaluation; Form 236 or 236 A Fire and Safety Checklist; Residential Habilitation Plan; Form FC-DOC4 Statement of Affirmation of Provisions of Residential Habilitation Services; Statement of Abuse and Neglect; certificates of awards; and copy of approved substitute provider.

15. Completes Form 239 Monthly Checklist, with comments as appropriate. Based on review of Form 239, writes a brief progress note with observations, recommendations for corrective action or follow-up, if warranted.

16. Ensures that each Family Care provider maintains a notebook containing pertinent information received concerning the individual to include a copy of the Residential Habilitation Plan; Menstrual Record, where appropriate; Medication Chart; Personal Allowance Ledger; listing of all call emergency procedures; as well as a binder with Parts NYCRR.

17. Ensures that each Family Care provider is invited and encouraged to attend the semi and annual review regarding the individuals residing in her home.

18. Ensures that the activity code Family Care Residential Habilitation (FCHR) is recorded once for each Family Care home the individual has been living in during that month. All movement must be accurately entered into the Tracking and Billing System (TABS).

19. Ensures that issues affecting the family, (death, divorce, loss of income, domestic violence, abuse and neglect, serious illness, stress) are addressed, and referrals made, as necessary.

20. Ensures that the Family Care provider is treated with dignity and respect. Develops ISP and Service Coordination Agreement for all MSC enrollees.

21. Contacts the Family Care provider if the individual has been ill for more than two (2) days or visits the Family Care home if the individual has been ill for more than five (5) days and is unable to attend his day program (ref. *Family Care Manual* Policy 10.4.2.

22. Visits the Family Care home when substitute provider service is provided during each five (5) day period throughout the duration of substitute service (ref. Family Care Policy 10.8.6).

In the delivery, management, or supervision of residential habilitation services, the provider must be able to demonstrate the involvement of a Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR 483 Chapter IV (10-1-92 Edition) Health Care Financing Administration, HHS.

A QMRP must have at least one year of experience working directly with individuals with mental retardation and developmental disabilities, and holds at least a bachelor's or master's degree in a professional category. These staff must be licensed, certified, or registered with the New York State Department of Education, as applicable, to provide professional services.

QMRP Responsibilities

1. Ensures that each individual receives services in accordance with his or her Individualized Service Plan (ISP), and the residential habilitation plan by reviewing or ensuring the review of the plan on a semiannual basis or as frequently as necessary.

2. Ensures that information entered in the residential habilitation plan is legible, accurate, up-to-date, signed, and dated.

3. Ensures that the individual's residential habilitation plan is integrated, coordinated, and monitored.

The QMRP must be licensed, certified or registered in one of the following professional categories:

1. **Occupational Therapists**

   To be designated as an occupational therapist, an individual must be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

2. **Occupational Therapist Assistant**

To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

3. **Physical Therapist**

To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

4. **Physical Therapist Assistant**

To be designated as a physical therapy assistant, an individual must be eligible for registration by the American Physical Therapy Association or be a graduate of a two-year college level program approved by the American Physical Therapy Association or another comparable body.

5. **Psychologist**

To be designated as a psychologist, an individual must have at least a master's degree in psychology from an accredited school. The individual must be licensed and currently registered by the New York State Education Department.

6. **Applied Behavioral Sciences Specialist**

To be designated as an applied behavioral science specialist, an individual must hold a master's degree from an accredited program in a field of psychology and has at least one year of experience in the assessment and development of behavioral programs for persons with developmental disabilities. A licensed psychologist must supervise this individual.

7. **Social Work**

To be designated as a social worker, an individual must:

a. Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or

b. Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council of Social Work Education or a comparable body.

c. Hold certification and registration from the New York State Education Department as a social worker.

8. **Registered Nurse**

To be designated as a registered nurse, the individual must be licensed and currently registered as a registered nurse by the New York State Education Department.

9. **Speech Language Pathologist or Audiologist**

To be designated as a speech and language pathologist or audiologist, an individual must:

a. Be eligible for a certificate of Clinical Competence in Speech Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body; or

b. Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

10. **Recreation Staff**

To be designated as a professional recreation staff member, an individual must have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

11. **Dietician**

To be registered as a professional dietician, an individual must be eligible for registration by the American Dietetics Association.

12. **Human Services Professional**

To be designated as a human services professional, an individual must have at least a bachelor's degree in a human services field, including but not limited to sociology, special education, rehabilitation counseling and psychology.

Each individual living in Family Care is entitled to nursing oversight. Such oversight must be provided at least every three months or more frequently based on the needs of the individual and/or provider.

The practice of nursing in Mental Retardation and Developmental Disabilities is characterized by those aspects of clinical nursing care that focus on maintenance of positive health, and development of skills in daily living, communication, socialization, and participation in community life. These activities include but are not limited to:

1. Teaching individuals positive health practices.
2. Preventing disease.
3. Maintaining good health.
4. Ensuring that care is provided during acute illness episodes.
5. Articulating knowledge and nursing skills so that they may be coordinated with the contributions of others working with the individual.
6. Acting as a liaison between the health care community, the Family Care provider, the individual, family members, and other professionals to obtain, and ensure service delivery consistent with each individual's identified health care needs.
7. Assisting in training Family Care providers in medication administration, and record keeping.

Role of the Registered Nurse in Family Care

1. Reviews, and has knowledge and understanding of the regulations, policies and procedures governing Family Care.
2. Supports the individual's increased independence in identifying health care needs and increasing services.
3. Participates in plans to consider moving individuals to Family Care to ensure that health needs can be adequately addressed in a particular home.

4. Reviews health care documentation prior to movement to ensure that the physical examination as well as immunizations, PPD, and psychological evaluation, if appropriate, are completed.

5. Visits the Family Care home at least once every three months or more often if needed to ensure that health services outlined in the Plan of Care reflect the individual's needs, and that such needs are being adequately addressed. These visits must be documented by the nurse.

6. Reports concerns of safety issues to the Family Care Coordinator, Family Care Home Liaison, Medicaid Service Coordinator, and/or other administrative staff as necessary.

7. Acts as a mentor, and consultant to Family Care providers to assist them to interact effectively with most health care professionals and to act as health care advocates.

8. Ensures that all medication is prescribed, obtained, provided, received, administered, safeguarded, documented, refilled, and/or disposed of in a manner that ensures the health, safety, and well-being of the individuals being served New York Codes, Rules and Regulations {14 NYCRR Section 633.17 (a) (7)}.

9. Ensures that information is provided to the individual, advocate, Family Care provider, and other providers about the condition for which a medication is to be used, and the specifics regarding administration {14 NYCRR Section 633.17 (a) (13) (ii)}.

10. Ensures that a review of the individual's medication regimen is conducted on no less than a semiannual basis {14 NYCRR Section 633.17 (18)}.

11. Ensures that an annual, or more often if significant changes have occurred with the individual's nursing assessment and it is available as a basis for health care planning. The assessment must include an evaluation of the individual's ability to self-administer medications.

12. Ensures that the individual is referred for routine, and/or specialized health services as needed, and that such services are provided in a timely manner.

13. Refers medical concerns to the primary provider or specialty care provider as appropriate.

14. Provides information to Family Care providers concerning infection control and/or necessary testing and reimbursement such as Tuberculosis (TB).

15. Ensures that the individual and family member/advocate is informed with regard to any major medical needs and that the procedures for informed consent are followed.

16. Ensures confidentiality of all communications, and health records are being safeguarded in conformity of law.

17. Attends admission/discharge planning meetings and visits the individual in the hospital. Attends meetings with medical staff as requested.

18. Requests, and reviews a copy of consultation reports, and all other pertinent medical documents, specialty medical services, etc. and follows up as needed.

19. Completes a "Ready-to-Go" packet for each individual that is updated annually or more often if there is a change in medication or health care status.

The Registered Nurse must be knowledgeable on applicable State laws and regulations on nursing care. Nursing is practiced in cooperation and collaboration with other members of the team and providers of service.

A psychological assessment is not required for individuals moving into or currently living in Family Care if there is sufficient information in the individual's record to complete the diagnosis and adaptive behavior deficit and/or learning portions of the Annual Level of Care Evaluation for Determination (LCED) information for waiver enrollment.

Prior to an individual moving into a Family Care home, or as part of the preenrollment evaluation for the Home and Community Services (HCBS) waiver, the individual must have a current or updated social assessment completed by a social worker or under the supervision of a certified social worker. The assessment is an identification and understanding of the individual's personal and social development, and must include the individual's needs, choices, personal, and social strengths. The assessment is to be completed so as to provide the individual, and professionals with information for developing intervening strategies, and serving as a measure of the individual's progress while in Family Care. The social assessment must be updated for the Annual Level of Care Redetermination Evaluation for the HCBS waiver.

June 1998	FAMILY CARE ACTIVITIES	Policy 10.7.9

All individuals in Family Care should participate in appropriate activities each week according to his or her ability and based on his or her choice, unless a physician certifies in writing such activity(ies) would be medically inadvisable. Activities for senior citizens, competitive employment, school, day services etc., may take place in community settings or at the Family Care home and/or at a combination of these. Such activities are to be appropriate to ability, age, sex of the individual, and are to meet the goals, preferences, and valued outcomes set forth by the individual, his or her advocate, the team, and other interested parties.

June 1998	FAMILY CARE REVIEW AND DISCUSSION OF RECREATIONAL NEEDS AND ACTIVITIES	Policy 10.7.10

Each individual living in a Family Care home is to participate in a variety of recreational and/or leisure activities on a regular basis, both in, and out of the home. Whenever possible there is to be an opportunity to participate in vacations, either with, or separate from the Family Care provider.

The Individual's Individualized Service Plan (ISP) must describe the types of recreational and/or leisure activities of which the individual is interested, and will participate. These may include a wide range of activities which take into account the age, needs, personal goals, preferences, interests, and physical abilities of the individual. These activities may include such areas as: volunteerism, creative arts, fine and gross motor skills, socialization skills and leisure activities.

The Family Care provider is to ensure that each individual has adequate recreational and/or leisure supplies within the Family Care home based on the individual's need (s) as identified in the ISP.

The provider is responsible for ensuring that the individual is able to attend the recreational and/ or leisure activities as described in the Residential Habilitation Plan.

The integration of an individual into the family will include recreational trips. Examples of such trips may include vacation with the family or over night or day trips to participate in recreational and/or social activities. When these trips occur, it is appropriate for an individual to share equally in the total or overall expense of the recreational trip. The individual's share of the expense is determined by dividing the actual cost of the trip by the total number of participants including the provider and provider's family. Such expenses, which should have been included in the Personal Expenditure Plan (PEP), may include, but are not limited to, gas, toll, and parking (see *Policy 10.4.7 Scheduled Absences)*. The individual's costs would include items such as food, lodging and tickets to amusement activities. The individual cannot share any incidental costs, such as automobile repairs and fines. The sponsoring agency does not reimburse the Family Care provider for these types of trips.

It is the responsibility of the Family Care provider to inform the Family Care Home Liaison of the intent to take people on a recreational trip that requires the individual to spend a significant amount of their personal allowance ($50), and request approval to use personal allowance and/or the clothing supplement (809 funds) for the expenses of the trip. If the individual has personal and other needs, the clothing funds may not be used.

Rev. July 2003	FAMILY CARE DESIGN AND IMPLEMENTATION OF THE INDIVIDUALIZED SERVICE PLAN	Policy 10.7.12

The Medicaid Service Coordinator (MSC), the individual, the advocate, and with input from the Family Care provider or other service providers, must design an Individualized Service Plan (ISP) to be implemented with and for each individual no later than *60* days after person receives Medicaid Service Coordination. The ISP is a readable and written personal plan. It is considered the "parent" plan or "blueprint", and is designed by using the person-centered approach to planning. (Reference the chapter on "The Individualized Service Plan" *The Key To The Home and Community Based Services Waiver: A Provider Guide).*

As a "blueprint" for achieving the individual's valued outcomes, the ISP communicates and coordinates important information. It is, therefore, a document critical to the individual, his or her advocate, Medicaid Service Coordinator, service providers, Family Care Home Liaison (FCHL), and administrators. The ISP is kept up-to-date as the individual's life and decisions change.

Each Individualized Service Plan (ISP) includes:

1. Individual Profile, which is a narrative or "picture with words" about the individual. It summarizes some or all of what was learned about the individual during the planning process, and must include the individual's personal valued outcomes. The profile communicates personal, and sometimes delicate, and confidential information that will assist those people helping the individual to achieve personal outcomes with sensitivity, and understanding of what is important to the individual.

   This might include preferences, interests, needs, desires, talents, skills, choices, personality, abilities, and other areas discovered while gathering information for planning purposes.

2. Developing activities, supports, and services that define the person's Individualized Service Environment (ISE). Each activity, support, or service chosen by the individual is documented in Section 2 of the ISP. This information must include activities, supports, and services currently being received but can include assistance the individual needs or hopes to receive in the near future, as long as it is clear the individual agrees he or she does not expect that assistance at the current time

3. Identification of natural supports, and community inclusion activities. Examples are churches, the YWCA/YMCA, cultural organizations, continuing education, self-help groups, health clubs, reading clinics, transportation, hobby or collectors clubs, volunteers, neighbors, grocery clerks, family members.

4. Plans for services, and activities, including description of the Family Care provider's responsibilities, with strategies of interventions, timetables and outcomes.

5. Documentation of review of the appropriateness to remain in the current Family Care setting.

The Individualized Service Plan (ISP) must reflect participation at a site other than Family Care home for a major portion of an individual's day. However, this does not preclude the development of interventions to be carried out at the Family Care home or by the Family Care provider in some instances. It is expected that on a five-day week basis, the majority of the day should be spent in age appropriate programs, services or activities unless, a physician certifies in writing that part or all of the activity would be medically harmful to the individual.

Reviewing and Updating the ISP:

The Medicaid Service Coordinator reviews the ISP at least every six months. The MSC, if elected, also ensures that Sections 1 and 2 of the ISP are kept current. The individual may choose plan of care support services in lieu of the Medicaid Service Coordinator, if approved by the DDSO.

The ISP review meetings with the individual, his or her advocate, the Family Care provider, and other service providers are beneficial because sharing and communicating information is always valuable. These meetings may be coordinated with those held by service providers to review their own plans, (such as residential habilitation, day habilitation, pre-vocational and supported employment).

FAMILY CARE
MAINTENANCE OF THE INDIVIDUALIZED SERVICE PLAN AND DISTRIBUTION TO THE FAMILY CARE PROVIDER

1. Maintenance

It is the responsibility of each sponsoring agency to maintain a copy of the Individualized Service Plan (ISP) for each individual living in Family Care. Each Family Care provider, within forty-five days (45) of the ISP review date, must receive a copy of the ISP containing pertinent information to facilitate the Family Care provider's care of the individual. This information must include all interventions, including medical, for which the provider is responsible, as outlined in the Residential Habilitation Plan.

2. Periodic review

The Medicaid Service Coordinator (MSC), if the individual has elected to have a MSC or in the absence of the Medicaid Service Coordinator, the Family Care Home Liaison (FCHL) or QMRP, is responsible for initiating, and conducting the mandated semiannual review, or more frequently as needed or requested, of the ISP as per waiver requirements. Additional reviews may be scheduled as deemed necessary by the individual, Medicaid Service Coordinator, and other professional staff. The MSC ensures that the necessary information is completed, and recorded in an individual's ISP after each review.

3. Modification(s)

It is essential that anyone, including the Family Care provider, who provides services to an individual in Family Care call attention to any portion of the Individualized Service Plan (ISP) or Residential Habilitation Plan which is not in an individual's best interest. Notice that such a problem exists in the ISP is to be directed to the Medicaid Service Coordinator, and problems with the Residential Habilitation Plan to the Family Care Home Liaison. The Medicaid Service Coordinator, and the Family Care Home Liaison are responsible for investigating and following-up when notified of any such circumstances.

The New York State Early Intervention (EI) Program was established under Title II-A of Article 25 of the Public Health Law. The Early Intervention Program is a statewide program that provides many different types of early intervention services to infants and toddlers, ages 0-3, with disabilities and their families. In the EI Program a disability means "a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay."

The New York State Department of Health (DOH) is the lead agency responsible for the Early Intervention Program. The New York State Office of Mental Retardation and Developmental Disabilities and the State Education Department, and others, are designated as state early intervention service agencies. This allows for a comprehensive and coordinated effort in meeting the needs of children with disabilities and their families.

There is an Early Intervention Official in all counties and the City of New York. The EI Official is the single point of entry into the EI Program. Therefore, all children who may need early intervention services must be referred to the EI Official. New York State public health law requires certain professionals, called primary referral sources, to refer infants and toddlers suspected of having a disability to the EI Official. However, no professional can refer a child to the EI Official if the child's parents object to the referral. Family Care providers are not primary referral sources, but should be knowledgeable about the EI Program in order to make appropriate referrals of children they suspect of having a disability and/or provide families with information that will enable them to access the EI Program. Parents, by birth or adoption, or person in parental relation to the child (see Glossary for complete definition), can also refer their own child to the EI Official.

Upon referral, the EI Official assigns an initial service coordinator to help the family with all steps in the EI process, from the child's multidisciplinary evaluation to the first Individualized Family Service Plan. The multidisciplinary evaluation will determine if a child is eligible for EI services and gather facts that will help parents make good decisions about services that may be needed. If a child has a diagnosed disability, the child will be eligible, but will need a multidisciplinary evaluation.

If a child is found to be ineligible for EI services, the initial service coordinator can help the family to make connections with other services and supports in the community. Families who disagree with an ineligible finding can request mediation or an impartial hearing to challenge the decision.

If a child is eligible for the EI Program, an Individualized Family Service Plan (IFSP) must be completed. The IFSP is the written plan for EI services the child and family will receive. This includes services, other than EI, that may be needed by the child and family. At the first IFSP meeting, parents are asked to choose an ongoing service coordinator. That person can be the initial service coordinator or someone else qualified to be a service coordinator.

Services available under the EI Program include:

1. Assistive technology devices
2. Assistive technology services
3. Audiology
4. Family training, counseling, home visits and parent support group
5. Medical services only for diagnostic or evaluation purposes
6. Nursing services
7. Nutrition services
8. Occupational therapy
9. Physical therapy
10. Psychological services
11. Service coordination
12. Social work services
13. Special instruction
14. Speech-language pathology
15. Vision services
16. Health Services
17. Transportation and related costs

Respite can be provided through the EI program. The provision of respite services are based on the individual needs of the child and family, and with consideration given to, certain criteria, such as:

1. Severity of the child's disability and needs
2. Child's risk of out-of-home placement if respite is not provided
3. Lack of other supports to the family

4. Presence of factors known to increase family stress, and
5. The need for respite expressed by parents

To the extent possible, EI services should be provided in natural environments. Natural environments are settings natural or normal for the child's age peers who have no disability, including the home, a relative's home when care is delivered by the relative, child care setting, or other community setting in which children without disabilities participate. EI services are provided at no cost to the parents. However, health insurance, including private insurance and Medicaid, is used to pay EI services.

When a child is transitioning from the EI Program to programs under Education Law and/or to other early childhood services, a transition plan is developed. The transition plan includes procedures to prepare the child and family for changes in service delivery, including steps to help the child adjust to and function in a new setting; procedures to prepare program staff or individual qualified personnel providing services to the child to facilitate a smooth transition; and, with parental consent, the service coordinator must incorporate the transition plan into the IFSP.

Children who are in the Care at Home and Home and Community Based Services waivers can also participate in the Early Intervention Program. In each DDSO there is a contact person who can answer questions regarding the EI Program.

A listing of the local DDSO EI contact person, as well as, a listing of the County EI Program numbers can be obtained from the local DDSO.

FAMILY CARE
OBJECTION TO AND APPEAL OF
INDIVIDUALIZED SERVICE PLAN (ISP)

Rev. July 2003 **Policy 10.7.14**

The Individualized Service Plan (ISP) for individuals enrolled in the Home and Community Based Services (HCBS) waiver is considered a "Plan of Care" under Medicaid rules, and a "Plan of Services" under New York Codes, Rules and Regulations (14NYCRR) Section §633.12. There are different due process rights for an individual under the regulations that govern both. Under Medicaid rules, an individual enrolled in the waiver has a right to request a Fair Hearing about the Plan of Care any time the sponsoring agency takes action to reduce or terminate HCBS waiver services. For more detailed information refer to the *Home and Community Based Services: Provider Guide*.

In addition to the Medicaid due process rights, an individual may object to a change in the plan of services, proposed placement or proposed discharge Pursuant to Section §633.12 of 14 NYCRR. Thus, when a sponsoring agency seeks to suspend, terminate or discontinue HCBS waiver services to the individual, the procedure set forth in Section §633.12 is applicable.

Pursuant to Section §633.12 of 14 NYCRR, each individual receiving services in an OMRDD certified program in the community, or his or her advocate, has the right to object to and appeal the Individualized Service Plan (ISP). The individual, and his or her advocate must be invited to attend a meeting to review progress and discuss changes to the ISP. Should informal discussion fail to result in agreement, the individual and the advocate are to be advised in writing of the right to object to the ISP and the procedures for making a formal written objection. However, a capable adult can object to any invitations or notifications being made, and may refuse objections or appeals initiated on his or her behalf.

(Reference –*The Key To The Home and Community Services Waiver: A Provider Guide)*

June 1998	FAMILY CARE OBJECTION TO AND APPEAL OF CARE AND TREATMENT	Policy 10.7.15

Pursuant to Section §633.12 of New York Codes, Rules and Regulations 14 NYCRR, each adult individual receiving services in an OMRDD operated or certified facility in the community, his or her advocate, and Mental Hygiene Legal Service (MHLS) have the right to object to and appeal any plan of services or part thereof and proposed change thereof, other care or treatment with which they disagree, plans for placement, or a proposal initiated by the agency/facility to discharge. However, this section does not apply to professional medical treatment for which informed consent is necessary. A capable adult may refuse the initiation of a formal objection or subsequent appeal on his or her behalf.

When in conformance with the requirements of the regulations, an individual and his or her advocate are invited to attend a team meeting to review progress and discuss changes to the service plan.

During the period that an objection is undergoing administrative review, an individual is to participate in programming mutually agreeable to the objecting party, the service provider, the individual, and his or her parent, guardian or advocate. Every effort feasible must be made to maintain the individual in at least his or her current level of activities. However, to protect the individual's health, safety, or welfare, or the health, safety, or welfare of others, nothing must preclude a change in activities for, or relocation or discharge of the individual. While an objection to placement or discharge is undergoing administrative review, relocation or discharge must only take place with the Commissioner's approval.

Treatment may be given, other than treatment for which informed consent is required by Section §633.11 or Section §633.13 of this Part and Section §681.13 of 14 NYCRR, to the individual, despite objection, in a situation where treatment is deemed necessary to avoid serious harm to life or limb of that individual or others, at the discretion of the chief executive officer and in accordance with the agency/facility or the sponsoring agency policies and procedures.

(Reference - *Community Placement Procedures.* Published: January 1992, Revised February 1995. OMRDD)

June 1998	FAMILY CARE SCHOOL NOTIFICATION PROCESS FOR SCHOOL AGE CHILDREN WHO MOVE INTO A FAMILY CARE HOME	Policy 10.7.16

1. The DDSO must notify both the school district where the Family Care home is located and the school district of residence within *ten* days after the date the child moves permanently into the Family Care home. For purposes of this process, the school district of residence is the school district where the child lived at the time. OMRDD "assumed responsibility for the movement, support and maintenance" of the child.

   However, for a child who was in the care or custody of a local social services district commissioner, including the New York City Child Welfare Administration, when moving into a Family Care home, the DDSO must notify both the school district where the Family Care home is located and the school district where the child lived at the time he or she cam into the care or custody of the local social services commissioner.

   Note: *The new notification process, however, does not apply to a child who has resided in a developmental center at any time and moves to a Family Care home. DDSOs should use the STAC notification process for such children.*

2. Notification to the school should include the name of the child, and any information that helps to identify the school district as the school district of residence. School notifications should be mailed to the district superintendent. Whenever the school district that must be notified is located in New York City, the DDSO should send notification to the superintendent of the community school district. The DDSO is encouraged to send notification to the school districts by certified mail, return receipt requested.

3. If a school district believes it is not the district of residence, it has ten days from the receipt of this information to send to the DDSO information proving that it is not the school district of residence.

4. The DDSO has five days after receiving such information from the school district to make a final determination on the school district of residence.

5. If the notified school district of residence fails to send additional information within the ten-day period, then that school district will be considered the school district of residence.

6. However, if the school district of residence does send information and the DDSO determines that they are not the school district of residence, then the process begins all over again and notification must be sent to the correct school district of residence, and to the school district where the Family Care home is located.

7. A school district can appeal to the commissioner of the State Education Department (SED) and the SED commissioner will make a final determination.

8. The DDSO will be fiscally liable if the DDSO fails:

   a. to make a reasonable effort to identify the appropriate district of residence of the child,

   b. to provide timely notice to the school district, or

   c. to make a final determination in a timely manner.

Federal and state law requires that an Individualized Education Program (IEP) be written for an individual residing in a Family Care home who is 21 years old or younger and is attending a school, BOCES, or a preschool program. An IEP is a statement that sets learning goals for the student and describes the services and programs that the school district will provide.

In New York State, the Committee on Special Education (CSE) develops the IEP for students ages five through 21; the Committee on Preschool Special Education (CPSE) for students younger than five years old.

The membership of the CSE/CPSE must include at least the student's teacher, a school psychologist, a school district representative who is qualified to provide, administer or supervise special education, a school physician, and a parent of a child with a disability residing in the school district, provided such parent is not employed by or under contract with the school district. The CPSE must also include a representative from the municipality.

The CSE/CPSE may, or even at times be required, to invite other school personnel and professionals to participate in the IEP meeting(s). *For example, the CSE must invite the DDSO to participate in any proceeding of the committee where the child is at risk of residential placement. At such meetings, the DDSO representative should advise the committee about OMRDD services and supports available to the family that might help avoid such a placement.*

The CSE must also ask a DDSO staff member to attend IEP meetings where the purpose is to plan transition services for the student. If the DDSO representative is unable to attend the meeting, the CSE must provide another opportunity for the DDSO's input in the planning process. Transition services must be specifically dealt within the student's IEP beginning at age 15, or earlier, if appropriate. Transition services are defined as a coordinated set of activities that promote movement from school to a post school environment.

In addition to the roles mentioned above, DDSO staff may also advocate for or lend support to the parent or student during IEP meetings, as well as serve as a language translator (see below). The Family Care provider may also attend CSE/CPSE meetings, if invited by the committee, the student's parent(s), or the student to present information, to lend support, to advocate on behalf of the student or parent, or to provide language translation services.

The Family Care provider and Family Care Coordinator/Medicaid Service Coordinator are encouraged to contact both the CSE chairperson and the student's teacher to express an interest in attending committee meetings to develop the student's IEP. The Family Care provider and coordinator should also encourage the student's parent(s) to participate in the IEP process. The required contents of an IEP are found in the Part '200.4 Regulations of the Commissioner of Education. The IEP must include:

(1) A description of the student's present level of performance and his or her educational needs.

(2) The type of disability the student has, as defined by these regulations. Disability classifications include: autistic, deaf, deaf-blind, emotionally disturbed, hard of hearing, learning disabled, mentally retarded, multiply disabled, orthopedically impaired, other health-impaired, speech impaired, traumatic brain injured, and visually impaired.

(3) Annual learning goals, short-term instructional objectives, an evaluative criteria, evaluation procedures and schedules to be followed during the period beginning with placement and ending with the next scheduled review by the committee. The annual goals must be consistent with the student's needs and abilities.

(4) The recommended program or types of services, the class size, if appropriate, and the extent to which the student will participate in general education programs, including:

(a) physical education or adaptive physical education;

(b) occupational education, if appropriate; and

(c) the general education classes in which the student will receive consultant teacher services.

(5) Transition services for students beginning at age 15 or younger if determined appropriate.

(6) The date the student will start receiving special education and related services, the amount of time per day the student will receive such services, whether the student is eligible for a twelve-month special service and/or program, the provider(s) of services during the months of July and August, and the expected date for reviewing the student's need for such services.

(7) The types of specialized equipment and adaptive devices the student needs to benefit from education.

(8) The types of testing modifications the student will need.

(9) The recommended placement or setting, (e.g., BOCES or a middle school).

The CSE/CPSE must invite the parent(s) to the IEP meeting(s), and inform him or her about the purpose of the meeting and who will be attending. It must also provide a language interpreter if the parent requires one.

The regulations, however, do allow the CSE/CPSE to hold the IEP meeting without the parent if he or she can't attend. If a parent is unable to attend, the CSE/CPSE is required to use other methods, including individual or conference telephone calls, to provide an alternative opportunity for a parent's participation.

The student, where appropriate, must also be given an opportunity to attend an IEP meeting(s). If the purpose of the meeting is to consider the need for transition services, the school district must invite the student and a representative of the DDSO. The district must provide a language translator if the student requires one.

Federal regulations state that the parent is to be an equal participant along with school personnel in developing, reviewing and revising his or her child's IEP. The parent may want to provide information on his or her child's educational (and, when appropriate, transition) needs, offer suggestions for the services appropriate for meeting those needs, or help select an appropriate program. At any time during the IEP meeting, the parent has the right to ask questions until he or she is clear about what is being discussed. A parent may invite others to attend the meeting to help present information, provide support, or help make decisions.

The school district must obtain the parent's written consent for the initial evaluation, the initial placement in special education, and the initial placement in a 12-month special service and/or program. If the parent does not grant consent for an initial placement within 30 days of the notice of recommendation, the board of education must initiate an impartial hearing to determine whether such placement is necessary without parent consent.

The parent, however, does not have to sign the IEP.

The IEP meeting serves as a communication vehicle between parents and school personnel to decide jointly what the student's needs are and what services will be provided to meet those needs. It provides an opportunity to resolve differences between families and school districts. If differences cannot be resolved at the IEP meeting, parents may request mediation or an impartial hearing with the school district or file a letter of complaint with the New York State Education Department, Office for Special Education Services, c/o Assistant Commissioner, One Commerce Plaza, 16th Floor, Albany, NY 12234.

During an impartial hearing process, if the parents and school do not agree on an interim placement, the child has the right to remain in the current program until the issue is resolved. Parents and districts are encouraged to resolve their differences through the use of mediation or some other informal procedure without going to a due process hearing.

After the IEP meeting has occurred, the parent will receive a notice describing the CSE/CPSE recommendation to the Board of Education. If the child has been recommended to receive special education, the parent will receive a copy of the child's IEP, and information about the tests, assessment reports and other factors used to make the recommendation. (The parent should also be provided a copy of the draft IEP before

the meeting.) All notices must describe any other options considered and explain why the proposed action was selected and a rationale for those options not selected.

The parent will also receive information about his or her due process rights, including impartial hearings, available free or low cost legal services, and reimbursement for attorney's fees in due process hearings and litigation if the parent prevails.

Once the recommendation is made, the Board of Education must provide an appropriate education program within 30 days of the Committee's recommendation. Notice of the placement must be provided to the parent, including information about the due process rights listed above.

The school district should initiate and conduct meetings to review a child's IEP periodically and, if appropriate, revise its provisions. Minimally, an IEP review meeting must be held once a year. This review should take into account current information about the student's performance and any additional evaluation information. The review must also consider the student's ability to participate in general education programs.

The CSE/CPSE must notify the parent of its intent to hold such a review, giving the parent the opportunity to participate in the review. After completing an annual review, the CSE/CPSE must inform the parents of its recommendation.

June 1998	FAMILY CARE CLOTHING AND PERSONAL SUPPLIES FOR INDIVIDUALS MOVING INTO FAMILY CARE	Policy 10.7.18

The sponsoring agency is to ensure that each individual moving to a Family Care home has adequate personal supplies, and clothing upon arrival, and that such clothing is appropriate to age, the season, and fits the individual.

The clothing must be in good repair and cleaned.

An inventory of the individual's clothing must be included in the individual's record as verification of the provision and receipt of the prescribed wardrobe/personal items.

SUGGESTED FAMILY CARE CLOTHING AND PERSONAL SUPPLIES GUIDELINES

		1-3 YEARS	4-5 YEARS	6-11 YEARS	12-18 YEARS
( )	Undershirt	6	4	4	Optional
()	Underpants	8	8	8	8
()	Pajamas	3	2	2	2
()	Socks	6	6	6	6
()	Panty Hose	-	-	-	4
()	Bra	-	-	-	4
()	Slip	-	-	-	2
()	Dress	1	1	1	4
()	Pullover Shirt	4	4	3	3
()	Blouse	-	-	3	3
()	Jeans/Slacks	4	4	3	3
()	Skirt	-	-	4	4
()	Sweater	2	2	3	3
()	Hat	2	2	2	2
()	Raincoat	-	1	1	1
()	Slacks (Dress)	2	3	3	3
()	Shoes	2	2	2	2
()	Sneakers	1	1	1	1
()	Belt	-	1	1	1
()	Light coat/jacket	1	1	1	1
()	Shorts	3	3	3	3
()	Swimsuits	1	1	1	1
()	Mittens/Gloves	2	2	2	2
()	Snowsuit/Ski jacket	1	1	1	1
()	Boots	1	1	1	1
()	Scarf	2	2	2	2
()	Suitcase	1	1	1	1

PERSONAL ITEMS

()	Car Seat	1	1	-	-
()	Toothbrush & Toothpaste	1	1	1	1
()	Sanitary Napkins	-	-	-	Yes

Prepared by: _____
(Name & Title)

Date: _____ Sponsoring Agency _____

Received by: _____
(Name & Title) Date

SUGGESTED FAMILY CARE CLOTHING AND PERSONAL SUPPLIES GUIDELINES

	BASIC LAYETTE:	0-6 Months	6 Months - I Year
()	Undershirts	6	6
()	Booties or socks	4	4- 6
()	Plastic pants	4-6	4- 6
()	Nightgowns, stretch suits, Sleepers, blanket sleepers	6	6
()	Dress-up clothes	2- 3	2- 3
()	Sweater and hat	2	2
()	Snowsuit or bunting bag	1	1
()	Bibs	2- 4	-
()	Cotton Jerseys	-	3- 6
()	Overhauls or pants	-	3- 6
()	Shoes	-	2
()	Mittens	-	2

	SPECIAL NEEDS:	0-4 Months	5 Months to I Year
()	Crib or port-a-crib or Bassinet or car bed	1	1
()	Car Seat (required by law in NYS)	1	1
()	10 Bottles, I Bottle Brush (or adequate bottle liners)		
()	4 Towels and Washcloths		
()	2-3 Crib Sheets		
()	3 Dozen Diapers (Unless disposable diapers are used)		
()	4-6 Receiving Blankets		
()	2 Crib Size Blanket		
()	2 Waterproof pads		
()	1 Rectal Thermometer		
()	1 Unscented soap of baby bath liquid		
()	1 Baby wipes		
()	6-8 Diaper pins, 1 diaper bag, 1 diaper pail (unless disposable diapers are used)		
()	1 Baby lotion		
()	1 Petroleum Jelly		
()	1 Cotton balls, Q-tips		
()	1 Rubbing alcohol		

OTHER DESIRABLE ITEMS:

() Infant Seat
() Swing
() Toys - mobile, exerciser
() Highchair
() Play Pen
() Stroller
() Suitcase

Prepared by: _____
(Name & Title)

Date: _____ Sponsoring Agency _____

Received by: _____
(Name & Title) Date

FAMILY CARE CLOTHING AND PERSONAL SUPPLIES GUIDELINES - ADULTS

Men

() 7 pr. briefs
() 7 tee shirts
() 7 pr. socks
() 5 pr. slacks/jeans
() 1 sport jacket and slack outfit
() 5 sport shirts
() 1 dress shirt
() 4 pr. pajamas - 2 light weight, 2 heavy weight
() 1 jacket
() 2 ties

() 1 raincoat
() 1 bathrobe
() 1 pr. galoshes, boots or overshoes
() 4 sweaters/sweatshirts
() 2 belts
() 1 winter coat
() 2 pr. gloves
() L hat
() 1 scarf
() 2 pr. casual shoes (e.g., work shoes, Sneakers, loafers or sandals)
() 1 pr. slippers
() 2 pr. dress shoes

Women

() 7 pr. briefs
() 7 bras or undershirts
() 7 pr. socks and/or stockings
() 2 slips
() 3 dresses
() 4 pr. slacks (2 dress & 2 casual)
() 5 blouses/shirts
() 4 skirts
() 4 pr. pajamas - 2 light, 2 heavy
() 1 bathrobe
() 1 raincoat
() 1 pr. galoshes, boots, or overshoes
() 1 jacket
() 4 sweaters/sweatshirts
() 2 pr. gloves
() 1 hat
() l scarf
() 1 winter coat
() 2 pr. casual shoes (e.g. work shoes, sneakers, loafers, sandals)
() 1 pr. slippers
() 2 pr. dress shoes
() 2 belts

PERSONAL ITEMS

() Toothbrush and paste
() Shaving gear (preferably electric)
( ) deodorant
( ) comb and brush
( ) shampoo

PERSONAL ITEMS

() toothbrush and paste
() shaving gear (preferably electric)
( ) make-up kit
( ) comb and brush
() sanitary napkins/tampons
() Deodorant

Prepared by: _____ Date _____
(Name & Title)

Received by _____ Date _____
(Name & Title)

June 1998	FAMILY CARE MAINTENANCE OF CLOTHING AND PERSONAL SUPPLIES INVENTORY FOR INDIVIDUALS IN FAMILY CARE	Policy 10.7.19

The maintenance of a clothing and personal supplies inventory for individuals living in Family Care is ultimately the responsibility of the sponsoring agency.

The Family Care provider, in conjunction with the home liaison, and the individual should do a clothing assessment to ensure that clothing continues to be appropriate in size and season, and determine if there is a need to replace and/or update the individual's wardrobe. The clothing and personal supplies guidelines for infants, young children and adults are no different from any other individual. The clothing assessment may be done prior to issuing the clothing payment.

Emergency Move - Permanent. An emergency move can be made whereby an individual is relocated, for permanent placement, to a new residential setting prior to completion of placement procedures. As soon as possible after the move is made, it is necessary to follow placement procedures as set forth in *Community Policy CP-2, Notification of Residential Placement;* and, if applicable, *Community Policy CP-6, Procedures When There Is An Objection to Placement.* If an emergency move is necessary while a planned proposed placement is undergoing the administrative review process because of a formal objection, the move can only be made with the Commissioner's approval, based on documentation that such a move is required.

Emergency Move - Transitional. When an emergency move is made to provide a transitional place of residence until a permanent placement can be effected. Examples would be: waiting for the actual opening of a new facility to which placement is already scheduled or due to unexpected closing of a residence because of fire, flooding, or hazardous conditions, resulting in a temporary residence being needed while a permanent placement is sought. The policies and procedures pertinent to placement do not have to be followed relative to that emergency move. However, if the individual is still at the transitional site location after 60 days, and permanent placement to another setting has not been proposed pursuant to *Policy CP-2, Notification of Residential Placement,* placement procedures for the transitional location have to be implemented. Nevertheless, an individual does not have the right to remain at a transitional place just because he or she objects to a proposed permanent placement.

Time Limited Services. An individual may be temporarily relocated for the purpose of receiving time-limited services elsewhere. This may be based on the recommendation of the individual's team; or, in a psychiatric emergency, based on the need for the individual to be taken to a psychiatric unit at a local hospital or other similar facility in the community, or to a State psychiatric center. If the individual receives time-limited services in the community and is away from the residential facility for more than a 24-hour period, she or he is to be placed on therapeutic leave. It is incumbent upon the sending facility to notify the individual's advocate, and Mental Hygiene Legal Services (MHLS) of the move as immediately as possible, and in writing within 24 hours, unless the individual is a capable adult and objects to such notification. For Willowbrook Class Members, notification is to be made to the plaintiff's attorney and others designated by the Willowbrook Permanent Injunction.

If a determination is made that the individual will need to remain in a place providing time limited services, i.e., treatment will take more than 60 days, such relocation is considered to be a "placement" and must conform, retroactively as necessary, to the following policies:

Policy CP-2	Notification of Residential Placement
Policy Cp-6	Notification When There Is An Objection to Placement

(Reference - *Community Placement Procedures,* Published January 1992, Revised February 1995, OMRDD)

December 2000	FAMILY CARE PREMARITAL COUNSELING FAMILY PLANNING AND SEXUALITY	Policy 10.7.21

Each individual living in Family Care is to be given the opportunity to access clinically sound instructions on the topic of sexuality and family planning services as well as information about the existence of these services, including access to medication or devices to regulate conception.

Each individual has a right to:

1. Freedom to express sexuality as limited by one's consensual ability to do so provided such expressions do not infringe on the rights or values of others.

2. Make decisions regarding conception and pregnancy pursuant to the mandates of applicable state and federal law.

3. The expression of sexuality within an appropriate location in accordance with a plan for effective management of the Family Care home.

4. Make decisions regarding conception or pregnancy.

The Medicaid Service Coordinator will arrange for family planning services including counseling for individuals living in Family Care homes who request or are in need of those services. The Medicaid Service Coordinator will also inform both consensual individuals living in the home and providers of the existence of such services.

The Family Care provider has a right to decline the moving in their home of an individual if the individual's sexual activity violates the provider's moral or religious beliefs.

There is no legal bar for a Family Care provider to become a guardian for an individual in his or her home. However, there are often reasons why this is not a good idea.

1. First and foremost is the issue of conflict of interest. For example, it may be that the individual needs to relocate to another setting in a different residential home and the family or provider and/or guardian may need the income to continue to maintain the home. Additionally, when a provider and/or guardian begins making treatment decisions on behalf of the individual that is in conflict with the team's clinical opinions, it is no longer a simple issue of removing the individual from the home and putting him or her into a setting where his or her needs will best be met.

2. On the other hand, many individuals need a guardian to help make day-to-day decisions, give important consents, and stand in the "legal shoes" of the individual. While these needs are intricately related to the individual's quality of life, the problems of having the decision maker being the Family Care provider with his or her own set of agendas may not serve the individual well in the long run.

SECTION 10.8

PROVIDER PAYMENTS

10.8.1 Difficulty of Care (ISPM Types, Payment Process and Requirements, Exceptional Circumstance Payments, Off-Line Payments, Advance Payment Procedures, Loss or Missing Checks)

10.8.2 Home Size Differential or Supplement

10.8.3 Difficulty of Care Supplement

10.8.4 Difficulty of Care Agency Sponsored

10.8.5 Requesting Payment for Damages

10.8.6 Emergency Respite Services

10.8.7 Payment for Substitute Provider Services

10.8.8 Recruiting Stipend (Finder's Fee)

10.8.9 Therapeutic Leave

10.8.10 Trial Visits

10.8.11 Respite Service in Family Care Homes for Families in the Community

10.8.12 Education Respite

Effective June 1, 1994 OMRDDs state sponsored Family Care providers became eligible to receive a monthly payment based upon the difficulty of caring for individuals in their home. These payments funded through Residential Habilitation under the Home and Community Based Services (HCBS) waiver, are in addition to the basic Supplemental Security Income (SSI-room and board) payment, and are called "Difficulty of Care "(DOC) payments. Family Care providers are eligible to receive a payment for all individuals living in their home receiving residential habilitation services regardless of the individual's eligibility for waiver or Medicaid services. Individuals who are not eligible or choose to not participate in the HCBS waiver are funded by the State.

1. **22 Day Payment Rule:**

The DOC payment is a monthly payment in addition to Supplemental Security Income (SSI) room and board, calculated on daily services. A certified Family Care provider is entitled to a full month's payment as long as the individual has permanently resided in his or her home for at least 22 days and the provider has delivered services to that individual based on the Residential Habilitation Plan. If an individual is temporarily out of the home and the Family Care provider does not deliver 22 days of service, the payment will be prorated. The prorated payment is based on the number of days that the individual resided in the home and received residential habilitation services.

Exceptions to the 22-day payment rule include admission to:

i. Hospital.
ii. Intermediate Care Facilities (ICFs).
iii. Health Related Facilities (HRFs).
iv. Skilled Nursing Facilities (SNFs).

If an individual has been admitted to any of the above facilities during the month, the Difficulty of Care payment will be prorated.

If an individual moves to another Family Care home, on a permanent basis, the provider payment is prorated for the number of days services were provided. The provider is paid for the day of admission and not the day of discharge.

If the Family Care provider has delivered 22 days of Residential Habilitation Services during the month, and she requires emergency respite services, a full month's DOC payment will be made. The DOC payment will be adjusted and paid on a per day basis, utilizing the Off-Line payment process, if less than 22 days of Residential Habilitation Services have been delivered during the month.

II. **Trips Exceeding 30 Days**:

If a provider chooses, with the approval of the DDSO, to take individuals on a trip exceeding 30 days, and a monthly visit to the home cannot be made; the DDSO must discontinue making DOC payments to the Family Care provider.

If the Family Care provider makes a written request to continue DOC payments while on vacation, a written agreement must be in place with an agency or qualified professional in the field of mental retardation and developmental disabilities. The written agreement assures a visit(s) to the provider's temporary residence to verify that Residential Habilitation Services are being delivered in accordance with the individual's Residential Habilitation Plan developed from the Individualized Service Plan (ISP). This verification must be provided to the DDSO before a payment can be made.

The cost for verification is the responsibility of the Family Care provider. The DDSO staff may provide technical assistance or contacts in other states. **Under no circumstance will DOC checks be sent to an out-of-state address.**

III. **Individual Service Planning Model (ISPM)/Developmental Disabilities Profile-2:**

The DOC payment is determined by the Individual Service Planning Model (ISPM) Type of the individual residing in Family Care. The ISPM Type is generated from the Residential Developmental Disabilities Profile-2 (DDP-2) completed at the time the individual moves into Family Care. A Residential DDP-2 must be input into TABS for each individual **permanently placed** into Family Care for a computer-generated payment to be processed for state-sponsored Family Care providers.

The DDP-2 is reviewed and updated by the DDSO staff, and the Family Care provider every two years as recommended by OMRDD's policy and procedures. At the time of the review, changes may be made. If changes in the DDP-2 impact the ISPM type, the DOC payment level will change accordingly. The new reimbursement level will take effect in the month following the month that the change is made. DDSO staff must exercise caution in the revision of the DDP-2 and must ensure that the information contained on the document accurately reflects the capabilities of the individual at that time. It is important to note that ***"changes** to the DDP-2 **do not necessarily impact** the ISPM type (payment) of the individual"*. It is the responsibility of the Family Care Home Liaison to inform the provider of any changes in the DOC payment prior to the effective date of the new payment.

Revisions to the DDP-2 may also be made if the needs of the individual change dramatically as a result of prolonged illness, hospitalization, or recuperation. In these instances the DDP-2 is reviewed to ensure that it accurately reflects the capabilities of the individual. It is also expected that a DDP-2 be revised when the individual recuperates from the illness.

IV. **The following two dimensions determine the ISPM Payment Levels:**

1. The DDP Adaptive and Health Scores are combined to estimate an individual's direct support level. In turn, the estimated direct support score is split into three direct support categories: *low, medium and high.*

2. The DDP Behavior Score predicts the frequency of behavior prevention and intervention. In turn, the behavior support level is split into two categories: *low and high.*

Since the ISPM types reflect all dimensions of an individual's challenges - adaptive, health and behavior- any change in these areas can cause a change in the ISPM type. However, to change an ISPM type the changes to the DDP must be significant enough to move an individual into a different *direct support category and/or behavior support category.*

The ISPM types were created so that approximately 25% of individuals would be *low direct support,* 50% would be medium, and 25% would be high. Behavior support categories were split so that approximately 25% of the individuals would be in the *high category*, and 75% in the *low.*

Each of these splits represents a doubling of support. For example, with each increase in the *direct support categories,* the estimated necessary direct support doubles. Similarly, the estimated frequency of behavior prevention and intervention doubles with the move from *low* to *high behavior supports.*

The following chart shows the six ISPM payment levels, created by splitting each direct support category by the levels of behavior support.

ISPM PAYMENT LEVELS		
ISPM TYPE 1	Low Direct Support/Low Behavior	$ 131.39
ISPM TYPE 2	Low Direct Support/High Behavior	$ 256.92
ISPM TYPE 3	Medium Direct Support/Low Behavior	$262.80
ISPM TYPE 4	Medium Direct Support/High Behavior	$388.32
ISPM TYPE 5	High Direct Support/Low Behavior	$762.57
ISPM TYPE 6	High Direct Support/High Behavior	$888.09

Rates are effective 4/1/04

V. **Exceptional Circumstances Payments**:

There are limited circumstances in which a provider receives "exceptional circumstance" payments that exceed the DOC reimbursement generated by an individual's DDP-2. These payments are made with the approval of Central Office Family Care/Upstate Regional Office. The approval is granted for one year, at which time a review of the individual's needs is required. The exceptional circumstance payment is input into TABS, and is paid in the same manner as the regular DOC payment.

The approval process requires a current DDP-2, Individualized Service Plan, Residential Habilitation Plan, and a detailed clinical summary that describes the individual's health and, medical, and behavior needs, if applicable. A psychological assessment and behavior plan will be required for any request due to any individual's challenging behaviors. The request must include the approval of the director or his or her designee.

VI. **Tracking And Billing Process (TABS) for State-Sponsored Family Care**:

Each month prior to the submission of a computer generated electronic file to the Office of State Comptroller (OSC), an Error Report will be run identifying individuals for whom a payment will not be generated as a result of critical information being incorrect or missing. These reports will be directed to the staff person (s) and a printer designated by each DDSO. This designation must be provided to Central Office Family Care/Upstate Regional Office. These reports must be used to verify and correct all errors listed on the report prior to the first payment run. For corrections made after the first payment run, *but before the last working day of the month,* Family Care provider payments will be made in the final payment run on the last business day of the month.

If the error report lists an individual who will be paid utilizing the Off-Line payment process, a notation should be made on the report for future reference.

The system will pay grandfathered individuals at the former variable rate level if it is **HIGHER** than the ISPM category until such time as that individual leaves his or her current Family Care home. The database that maintains this information matches the individual's TABS number with the Family Care provider's operating certificate number of the home. When an individual moves from one home to another, the payment is automatically terminated. Even if the move occurs in the middle of the month, the payment level will change effective with the date of the permanent move.

The system will pay a higher DOC payment for those individuals that were enrolled in personal care as of March 31, 1995. This higher payment will remain in place for as long as that individual remains permanently placed in the Family Care Program.

PLEASE NOTE: Permanent movements between homes have no effect on the payment. However, any discharge from Family Care to other residential settings will negate the payment.

VII. **Criteria to Report Monthly Family Care Residential Habilitation:**

See Memorandum

The following criteria must be met to use the Family Care Residential Habilitation (FCRH) reporting code for monthly reporting:

1. The individual **must** be in the Family Care home as a **permanent** resident (Add to program in TABS).

2. The individual **must** have a Residential Developmental Disabilities Profile - 2 score (DDP-2) which must be updated every two years. A DDP-2 **must** be entered into TABS during the month of placement into Family Care.

3. The Family Care provider **must** have a correct mailing address with correct zip code.

4. The Family Care provider **must** have their correct Social Security Number (SSN) which is confirmed by DDSO staff.

5. Direct deposit is available to those providers interested in participating. Forms and information may be obtained from the DDSO or for the Office of State Comptroller Web-site.

6. The activity code FCRH **must** be recorded once for each Family Care home the individual has permanently lived in during that month (All movements **must** be accurately entered into TABS). The Family Care staff **must** verify monthly and after a home visit, to confirm that services are being provided in accordance with the Residential Habilitation Plan (see attached sample of a Residential Habilitation Plan), using the reporting code FCRH, that activities were provided. Data entry staff may not input FCRH activity codes on an "exception basis." The format for providing this verification is according to each DDSO. Please note: It is necessary to verify that services were provided in all homes a Family Care individual was residing during the month of payment.

7. The service reporting information, by individual **must** be submitted to the staff person responsible for entering the data into TABS for billing and Family Care payment processing. The activity **must be entered prior to the first payment run of the month.** (Typically the 15th of the month).

Note: There is no TABS requirement to associate a primary staff assignment when reporting the FCRH code. However, Family Care Provider payments will only be processed when the program code (operating certificate number) of the Family Care home such as 4270001 is entered as the activity location code.

8. The Sponsoring Agency staff ensures that a Statement of Affirmation for Provision of Family Care Residential Habilitation Services (OMR- FCRH 194 - see Attached) be signed by each Family Care Provider verifying that she or he has provided services to individuals in accordance with each individual's

Residential Habilitation Service Plan for each month services were provided. The original must be retained with all DDSO Family Care Residential Habilitation documentation for a period of **six years.**

9. The Family Care Residential Habilitation supervisory staff (QMRP- Ref. Policy 10.7.5) must be responsible for ensuring that the services were provided, the TABS reporting document/Family Care roster information is accurate, and the completed monthly Statement of Service Provision is filed on a timely basis. The format used for service provision verification and documentation may be chosen by the DDSO.

10. Monthly Family Care Residential Habilitation Payment Reports and Residential Habilitation Error Reports are maintained at the DDSO for a period of one year.

NOTE: Although FCRH is a Monthly Code; Family Care Payments are calculated on services delivered on a daily basis.

Example 1. John Smith resides in the Family Care home of Dennis Brooks during the period June 1 - June 23. He moves to the Dalton Family Care home on June 23 as a permanent resident and remains there through the end of the month.

Requirement: Prior to July PAYMENT RUN, the DDSO Family Care Staff verifies that Residential Habilitation Services have been provided, and submits to data entry a FCRH activity for each home for the month of June. **Data entry staff must** ensure that a remove and add to program is entered into TABS for John Smith and also record the activity code for each home.

The automated payment system will calculate payments for providers as follows, paying for day of admission and not for day of discharge:

Provider Brooks - 22/30ths of monthly rate.

Provider Dalton - 8/30ths of monthly rate.

It is imperative that all movement data for Family Care individuals are input into TABS on a timely basis. Accurate Family Care census data in TABS will ensure correct Family Care monthly payments, and avoid additional DDSO workload reconciling Provider over/under payments and related administrative paperwork.

Example 2. John resided in Mrs. Dole's home the entire month of June.

Requirement: A member of the DDSO Family Care staff verifies that Residential Habilitation Services have been provided, and submits this information to data entry via a Roster or a DDSO specific TABS reporting document. Prior to the PAYMENT PROCESS an activity code for FCRH is input.

Example 3. From July 1 thru July 15th, Mark resides in respite status in the home of Mrs. Gold.

Requirement: Report the appropriate in residence status (Time Limited Admission), however, a FCRH Activity **WILL NOT** be recorded and a DOC payment will not be made. Mark is **not permanently placed in Family Care.**

Example 4. John resides in Mrs. Smith's Family Care home. On July 28th, John is placed into the hospital and returns to the home on August 1.

Requirement: John is placed on hospital leave as of July 28th. FCRH Activity is recorded for the month of July. The provider is paid for 27 days for Residential Habilitation Services. Residential Habilitation cannot be paid for the time the individual was in the hospital.

Example 5. Mrs. Atkins, a Family Care provider, is taking a 2-month vacation to Florida during the months of January and February. She will be taking Janet Cloutier, a consumer in her home on this extended vacation.

Requirement: To receive a DOC payment the following procedures must be met:

a. Preapproval of the vacation by the DDSO staff.

b. Residential Habilitation Plan reviewed and modified, as necessary.

c. The Family Care provider **must** obtain a qualified professional/agency to visit the home on at least a monthly basis or more often as required by the DDSO, to ensure that Residential Habilitation services are being delivered.

d. A written agreement with an agency or qualified professional in the field of Mental Retardation and Developmental Disabilities that provides monitoring of the delivery of Residential Habilitation Services. The Family Care provider **must** reimburse the professional /agency for these services.

e. A written verification **must** be submitted prior to the payment being provided.

Example 6. Marissa resides in the Springer Family Care Home. On July 17th, Marissa leaves for camp and returns on August 2nd.

Requirement: A FCRH Activity code **must not be entered**. The Family Care provider will be paid **Off-Line** for the days Marissa was in the home receiving Residential Habilitation Services (- 16 days).

VIII. **Manual Or Off Line Billing:**

When a Family Care provider is not paid via the automated payment system, through TABS, and the Office of State Comptroller interface, the DDSO is responsible for completing a "Family Care Waiver Billing Form Off-Line Payment Request" (see attached). A separate form must be completed for each provider that includes information for only those individuals residing in that home on a permanent basis for whom payment was not made. In addition to this form, a special charge voucher (AC- 916 see attached) must be partially completed and signed.

The fields that need to be completed are:

1. Originating Agency - OMRDD
2. Originating Agency Code - 51000
3. Payee ID - Family Care Provider Social Security Number
4. Payee Name - Family Care Provider Name
5. Address - Family Care Provider Mailing Address
6. City
7. State
8. Zip Code
9. Payment Amount
10. Total Number of Payees on the Voucher – 1
11. Total Amount of this Voucher

Everything else on the form should be left **Blank**. Forward the completed "Family Care Billing Form Off-Line Payments" and the voucher to:

NYS OMRDD
Division of Revenue Support
44 Holland Avenue
Albany, NY 12229

Providers with questions concerning payment should be directed to the DDSO designee responsible for this task. The DDSO contact person can direct inquiries to the Division of Revenue Support via telephone or E-MAIL.

PLEASE NOTE: An Off-Line Payment will NOT be processed during the month for which services are being paid.

IX. **Family Care Advance Payment Procedures:**

Step 1.

Each Business Office submits a Special Charge Voucher to pay each Family Care provider the full room and board rate, where the DDSO director is the representative payee.

Step 2.

On receipt of funds for the month for Supplemental Security Income (SSI), the Business Office issues Personal Allowance for the Family Care individual by mail to the Family Care provider. The balance of funds received is made available to reimburse the voucher payment. Each individual's amount is noted on the OMRDD Family Care Payment Form.

Step 3.

The difference between the amount refunded and the amount that was due becomes the outstanding amount that must be deducted from the next month's room and board payment. The Family Care provider and Medicaid Service Coordinator must be advised that this amount must be collected from the individual - normally this would be from wages either turned into the Business Office or managed by the individual. The individual may, if capable, pay the Family Care provider directly or the individual may choose to submit a 73A to the Business Office to take this payment out of any accumulated reserves at the Business Office.

Step 4.

For the first shortfall month only: The difference between the first month's amount refunded and the amount that was due becomes an amount outstanding to the State by the individual. The individual may repay this amount to the State out of wages or accumulated reserves.

X. **Lost or Missing Difficulty of Care Checks:**

In the event that a provider lost or is missing a Difficulty of Care check (DOC), the DDSO staff is responsible for:

a. Verifying that a check has been issued to the provider by using the month's FCHR Payment Reports.

b. Completing a *"Family Care Lost/Missing Check Request"* form, (see attached). The form must be sent to:

OMRDD Division of Revenue Support
44 Holland Avenue, Albany, New York 12229

Upon receipt of the completed form, the Division of Revenue Support (DARS) will contact the New York State Department of Taxation and Finance, Division of Treasury to ensure that the check has not been cashed. If the missing check has been returned to the Department of Taxation and Finance, it will be sent back to the OMRDD Division of Revenue Support, be photocopied for the OMRDD file, and sent directly to the Family Care provider.

If the missing check has not been returned to the Taxation Department, a STOP PAYMENT will be processed. This process will generate an APPLICATION FOR ISSUANCE OF A DUPLICATE CHECK. The Division of Revenue Support will forward the application to the Family Care provider with instructions for completing the form. The Family Care provider will return the completed application to the Division of Revenue Support. This application will produce a DUPLICATE check, which will be mailed directly to the Family Care provider.

If the missing check has been cashed, a copy of the signed canceled check will be sent to the DDSO who completed the form. If after reviewing the signature, the provider(s) indicates that it is not his or her signature, a letter stating the fact, must be signed by the provider and notarized, for issuance of a new check.

It is important for Family Care providers to **maintain records of payments** (reference Record Keeping Family Care Policy 10.14) as well as provide the DDSO staff with any changes in the provider's name and address. Obtaining a duplicate check can take many weeks and OMRDD does not have the ability to make loans to the provider during the check-processing period.

FAMILY CARE WAIVER BILLING FORM
OFF-LINE PAYMENTS

DDSO: _____ Contact Person: _____ Telephone # _____

Provider Name _____ Operating Certificate# _____

SS# _____ Telephone # _____

Provider Mailing Address: _____

Zip Code: _____

Services provided during the month of: _____ Year: _____

INDIVIDUALS SERVED:

NAME	TABS #	MED. ELIG. Y/N	ISPM/ GRNDFTHR AMT.PYMT	PC ADD ON	TOTAL MTHLY PYMNT	# OF DAYS	TOTAL PYMNT DUE
Res. Hab. Supplement *with CO Family Care Unit Approval							

GRAND TOTAL _____

EXPLANATION/JUSTIFICATION FOR THIS PAYMENT: (REQUIRED FOR PROCESSING)

_____

_____

_____

_____

HAVE PAYMENT REPORTS FOR THE SERVICE MONTH BEEN REVIEWED TO VERIFY THAT PAYMENT HAS NOT BEEN PROCESSED? YES ( ) NO ( )

Family Care Coordinator/Designee _____ **Date** _____

FC-DOC-1

FAMILY CARE LOST/MISSING CHECK REQUEST

DDSO: _____ Contact Person: _____ Phone # _____

Provider Name: _____

Operating Certificate #: _____ S.S. #: _____

Provider Mailing Address: _____

_____

Month of Service: _____ Payment Report Date: _____

Date of Check: _____ Amount of Check: _____

Explanation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ Date _____

Signature Family Care Coordinator or Other DDSO Staff

FC-DOC-2

DIFFICULTY OF CARE
PAYMENT CALCULATION

Date _____ **DDSO** _____

Family Care Provider _____

Number of Individuals Living in the Home _____ Services Provided to _____

_____

_____

_____

Part I

A). **ISPM Category** _____ **(1 - 6)** **Monthly Payment** _____

B). **Variable Rate** _____ **Yes** _____ **No** **Monthly Payment** _____

Part II

Home Size Differential _____

Difficulty of Care Supplement _____

Part III

Exceptional Circumstance Monthly Payment

NOTE: **Payments for exceptional circumstances will require approval by OMRDD Central Office Family Care Unit and payment level will be entered into the system by staff of the Family Care Unit.**

Calculation:

Part I	Payment (higher A or B)	_____
Part II	Payment	_____
Part III	Payment	_____
Difficulty of Care Payment (Total)		_____

FC-DOC-3

ADMINISTRATIVE MEMORANDUM - #2006-04

TO: **Executive Directors of Agencies Authorized to Provide Agency Sponsored Family Care Residential Habilitation**
Executive Directors of Agencies Authorized to Provide Medicaid Service Coordination
DDSO Directors
IBR Director

FROM: **Helene DeSanto, Executive Deputy Commissioner**

Gary Lind, Director
Policy, Planning and Individualized Services

James F. Moran, Deputy Commissioner
Administration and Revenue Support

SUBJECT: **FAMILY CARE RESIDENTIAL HABILITATION SERVICE DOCUMENTATION REQUIREMENTS**

DATE: **October 6, 2006**

Suggested Distribution:

Agency Sponsored Family Care Coordinators
DDSO State Sponsored Family Care Coordinators
Agency Sponsored Family Care Home Liaisons
DDSO State Sponsored Family Care Home Liaisons
Certified Family Care Providers
Agency Sponsored Family Care Billing Department Staff
MSC Service Coordinators and MSC Supervisors

Purpose

This is to review the Family Care Residential Habilitation service documentation requirements that support a provider agency's claim for payment (for Agency-Sponsored Family Care) and

OMRDD's claim for payment (for State-Sponsored Family Care). These requirements are effective November 1, 2006 for the payment for Family Care Residential Habilitation services provided to Home and Community Based Services (HCBS) waiver-enrolled individuals as well as to non-waiver enrolled individuals. In addition to the claim documentation requirements specified in this Administrative Memorandum (ADM), Family Care Residential Habilitation service provision must continue to comply with quality service standards set forth in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD 1997) and program requirements set forth in the Family Care Manual (OMRDD).

Background:

Title 18 NYCRR, Section 504.3 (a) states that by enrolling in the Medicaid program, the provider agency agrees "to prepare and **maintain contemporaneous records** demonstrating its right to receive payment under the medical assistance program and to **keep for a period of six years from the date the care, services or supplies were furnished, all records** necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to...the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health." It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for Family Care Residential Habilitation is 14 NYCRR sections 635-10.4(b) (1) and 635-10.5(B) (13).

Billing Family Care Residential Habilitation:

The billing unit or "unit of service" for Family Care Residential Habilitation is a day. There are two requirements that must be met before a day of Family Care Residential Habilitation can be billed:

1. The consumer must be permanently enrolled in the Certified Family Care Provider's home on that day.
2. The Certified Family Care Provider must deliver and document daily, **at least one face-to-face individualized Family Care Residential Habilitation service** that is drawn from the consumer's Family Care Residential Habilitation Plan.

Family Care Residential Habilitation billing is not permitted on days when the Certified Family Care Provider delivers no services to the consumer, even in cases when an approved substitute or respite provider delivers services on that day.

Documentation Checklist / Chart Formats:

For each day the Family Care Residential Habilitation service is billed, the Certified Family Care Provider (hereafter known as Family Care Provider) must document the required face-to-face

Family Care Residential Habilitation service using a checklist or chart. The service documented must be drawn from the consumer's Family Care Residential Habilitation Plan. A monthly summary note written by the Family Care Home Liaison is also required. The monthly summary note must summarize the implementation of the consumer's Family Care Residential Habilitation Plan, address how the consumer responded to the services provided during the month, and address any issues or concerns.

For State-Sponsored Family Care, a required checklist/chart format will be distributed to DDSOs under separate cover. For Agency-Sponsored Family Care, the attached checklist/chart format may be used to document services. Provider agencies may also elect to develop their own checklist/chart format, but it must include all the Service Documentation elements listed below.

Required Medicaid Elements for Service Documentation:

Documentation by the Family Care Provider: Medicaid rules require that service documentation be "contemporaneous" with the service provision. On a daily basis, the Family Care Provider must document the service provided when it occurs. Required service documentation elements are:

1. **Consumer's name and Medicaid Client Identification Number (CIN).** Note that the CIN does not need to be included in daily documentation; rather, it can appear in the consumer's Family Care Residential Habilitation Plan.
2. **Identification of category of waiver service provided** (i.e., Family Care Residential Habilitation).
3. **A daily description of at least one face-to-face service provided by the Family Care Provider** (e.g. the Family Care Provider documents that he/she "assisted the consumer to choose appropriate clothes for the day"). Each service delivered must be identified in the consumer's Family Care Residential Habilitation Plan.
4. **The date the service was provided.**
5. **The primary service location.**
6. **Verification of daily service provision by the Family Care Provider**. Initials are permitted if a "key" is provided which provides the signature and full name of the Family Care Provider.

Documentation by the Family Care Home Liaison: The following service documentation elements must be included in the monthly summary note:

1. **Consumer's name and CIN**. Note that the CIN does not need to be included in the monthly summary note; rather, it can appear in the consumer's Family Care Residential Habilitation Plan.
2. **Identification of category of waiver service provided** (i.e. Family Care Residential Habilitation).
3. **Month and year of summary note.**
4. **A summary of the consumer's response to services, implementation of the Residential Habilitation Plan and any issues or concerns.**

5. **Signature and title of the Family Care Home Liaison**.
6. **Date the monthly summary note was written** (must be written by the end of the month following the month of service, e.g. the November monthly summary note must be written by the end of December).

Other Documentation Requirements:

In addition to the checklist/chart and monthly summary note, the Family Care Sponsoring agency or the DDSO must maintain the following documentation:

- **A copy of the consumer's Individualized Service Plan (ISP)**, covering the time period of the claim, developed by the consumer's Medicaid Service Coordination (MSC) service coordinator or Plan of Care Support Services (PCSS) service coordinator. The Family Care Residential Habilitation Service must be identified in the "HCBS Waiver Service Summary" section of the ISP. The service must be described as follows:
    - **Name of Provider**: DDSO Name (for State-Sponsored Family Care) or the Agency Provider Name (for Agency-Sponsored Family Care)
    - **Type of Waiver Service**: "Family Care Residential Habilitation"
    - **Frequency**: "Day" or "Daily"
    - **Duration**: "On-going"
    - **Effective Date**: the date the person began receiving the Family Care Residential Habilitation service. Note: this date must be on or before the first date of service for which the Agency Provider or DDSO bills Family Care Residential Habilitation for the person.

- **A Family Care Residential Habilitation Plan** which includes the completed *Health and Safety Needs* form. The Plan is developed by the Family Care Home Liaison and the Family Care Provider that conforms to the Habilitation Plan requirements found in OMRDD ADM #2003-03. Attached to this ADM is the prescribed format for the Family Care Residential Habilitation Plan, including the *Health & Safety Needs* form. The Family Care Residential Habilitation Plan must "cover" the time period of the Family Care Residential Habilitation service claim. Note that the consumer's Family Care Residential Habilitation Plan is attached to his/her ISP.

Documentation Retention:

All documentation specified above, including the ISP, the Family Care Residential Habilitation Plan and service documentation, must be retained for a period of at least six years from the date of the service billed. Diagnostic information and other clinical records are generally maintained for a longer period of time and are not the subject of this memorandum.

Fiscal Audit:

In a fiscal audit a Family Care Residential Habilitation claim for a sampled consumer will be selected and the auditor will require the ISP and Family Care Residential Habilitation Plan in effect for the claim date. The auditor will also require, for the claim date, documentation of the daily residential habilitation service by the Family Care Provider and the Family Care Home Liaison's monthly summary note covering the month of the claim date.

For additional information on the documentation requirements, contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408-2096, Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647 or Ms. Joyce Cloutier of the Upstate Regional Office at (518) 473-6255.

Attachments

cc: Provider Associations
Kathy Broderick
Michele Gatens
Carol Metevia
Kevin O'Dell
David Picker
Joyce Cloutier

HCBS WAIVER SERVICE DOCUMENTATION

STATE SPONSORED FAMILY CARE RESIDENTIAL HABILITATION DAILY CHECKLIST

DDSO : _____

CONSUMER NAME: _____

FAMILY CARE PROVIDER: _____ (Print Name)

FAMILY CARE CO-PROVIDER: _____ (Print Name)

FAMILY CARE PROVIDER(S) ADDRESS: _____

PROVIDER SIGNATURE: _____ INITIALS: _____

CO-PROVIDER SIGNATURE: _____ INITIALS: _____

INFORMATION FOR TABS DATA ENTRY

CHECK (✓) APPROPRIATE MONTHLY ACTIVITY REPORTING CODE FOR THIS INDIVIDUAL

- ☐ FCRH *DOC FULL MONTH*
- ☐ No Billing
- ☐ Off-Line Billing

OP CERT # OF FAMILY CARE HOME: _____

DATA ENTERED BY: _____ (INITIALS)

DATE ENTERED: _____ (mm/dd/yy)

TABS ID: _____

MONTH/YEAR OF SERVICE DELIVERY: _____

DESCRIPTION OF THE INDIVIDUALIZED SERVICE / ACTION PROVIDED based on the consumer's Residential Habilitation Plan

Family Care Provider delivering the service or action initials the date the service or action was provided.
[Note: By entering initials, family care provider is attesting that the service or action was provided on that day. Initialing must occur at the same time as service delivery.]

Service or action : (DAY OF MONTH)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Service or action :																															
Service or action :																															
Service or action :																															
Service or action:																															

VERIFICATION STATEMENT

By signing and dating, I attest that I have reviewed the Family Care Residential Habilitation Daily Checklist including the "Information For TABS Data Entry" section, and that this form has been, to the best of my knowledge, completed accurately.

Home Liaison Signature ***Date***

EXCEPTIONS FOR HOSPITALIZATION, NURSING HOME PLACEMENT, ICF/DD OR OTHER LEAVES

Location	Dates

PLEASE ENSURE THAT THE MONTHLY SUMMARY NOTE IS ATTACHED TO THIS FORM.

STATE SPONSORED FAMILY CARE RESIDENTIAL HABILITATION

Directions for Completing the State Sponsored Family Care Residential Habilitation Daily Checklist

Family Care Identifying Information	
DDSO:	Name of DDSO.
Consumer Name:	"First Name/Last Name" of person receiving Family Care Residential Habilitation services.
Family Care Provider/Co-Provider:	Name of the Certified Family Care Provider/Co-Provider providing services/actions.
Family Care Provider Address:	Address of the Certified Family Care Home.
TABS ID:	Numeric code which identifies the consumer in TABS. For assistance in obtaining the TABS ID number, please contact your TABS Coordinator.
Month/Year of Service Delivery:	Calendar Month/Year of service provision.
Family Care Provider /Co-Provider Signature:	Family Care Provider/Co-Provider sign on available space.
Initials:	Family Care Provider /Co-Provider initials on available space.

Family Care Provider/Co-Provider Documents Services	
Description of the Individualized Staff Service/Action Provided:	Family Care Home Liaison writes a description of services/actions that are drawn from the consumer's Residential Habilitation Plan.
Family Care Provider must initial the date the service/action was provided:	Family Care Provider/Co-Provider initials in the space beneath the appropriate service date, documenting the provision of the service identified in the first column. By entering initials, the Family Care Provider/Co-Provider is attesting that the service or action was provided on that day. Initialing must occur at the same time of service delivery.

Family Care Home Liaison	
Verification Statement:	Family Care Home Liaison signs and dates on available space. By signing and dating, the Family Care Home Liaison is attesting that the Family Care Residential Habilitation Daily Checklist and the Information for TABS Data Entry section has been, to the best of his/her knowledge, completed accurately.

Family Care Exceptions	
Exceptions:	Hospitalization, Nursing Home Placement, ICF/DD or Other Leaves must be documented by the Family Care Provider/Co-Provider by stating the Location(s) and Date(s) of Leave. Family Care Home Liaison or other designated staff verifies leaves as necessary.

STATE SPONSORED FAMILY CARE RESIDENTIAL HABILITATION

Directions for Completing the State Sponsored Family Care Residential Habilitation Daily Checklist

Page 2

Information for TABS Data Entry	
The Family Care Home Liaison or other designated staff verifies leaves and inputs into TABS.	
Check the appropriate monthly code that corresponds to the consumer's countable service days during the month. *Countable Service Days are days on which at least one face-to-face Family Care Residential Habilitation service was provided and initialed by the Family Care Provider.*	
FCRH: Check this code when:	The consumer was in the home and received 22 or more countable service days during the month or The consumer was in the home and received 22 or more countable service days during the month and the consumer was in a hospital, nursing home or ICF/DD during the month and this leave was input into TABS or The consumer was permanently enrolled in two homes during the month and received services in both homes.
Off-Line Billing: Check this code when:	The consumer was not in the home for 22 days and did not receive a minimum of 22 countable service days of Family Care Residential Habilitation (e.g. temp out of the Family Care home). A copy of the checklist is sent to the Family Care Home Liaison or designee for off-line processing.
No Billing: Check this code when:	The consumer was not in the home during the month and received no face-to-face Family Care Residential Habilitation services.
Op Cert # of Family Care Home:	Enter the ID # that has been assigned to the Family Care Home where the consumer was enrolled during the month. If the consumer was enrolled in two homes during the month, an FCRH activity must be entered for both homes. [Note: for assistance in obtaining the Op Cert #, please contact your DDSO TABS Coordinator.]
Data Entered By:	Enter the initials of the DDSO staff member who is entering the monthly activity reporting code into TABS.
Date Entered:	Enter the date the service reporting information was entered into TABS.
Reports:	Ensure that the error, first final and second final reports are copied and maintained for a period of one year in a designated office at the DDSO.

Family Care Residential Habilitation Plan
Health & Safety Needs

Name _____

Medicaid CIN # _____ TABS ID # _____

Behavior _____

_____

_____

_____

Medical _____

_____

_____

_____

Fire Safety _____

_____

_____

_____

Level of Supervision both in the home and in the community _____

_____

_____

_____

Other Needs _____

_____

_____

_____

Developed by _____ Title _____ Date _____

AC 916 (Rev. 12/88) STATE OF NEW YORK

Voucher No.

Originating Agency				Orig. Agency Code	Interest Eligible (Y/N)
Payment Date (MM) / (DD) / (YY)	OSC Use Only			Liability Date (MM) / (DD) / (YY)	
Payee ID	Additional	Zip Code	Route	Payee Amount	
Payee Name (Limit to 30 Spaces)				IRS Code (Formerly 1099	March/Inv. Rec.d Date (MM/DD/YY)
Payee Name (Limit to 30 Spaces)				Statistics Type	Statistics
Address (Limit to 30Spaces)				Ref/Inv. No. (Limit to 20Spaces)	
Address (Limit to 30 Spaces)				Ref/Inv. Date (MM) / (DD) / (YY)	
City (Limit to 20 Spaces)	State	Zip Code			

DESCRIPTION OR REASON

*Total Number of payees on this Voucher		Total Amount of this Voucher	

To the State Comptroller:
Please issue your warrant in favor of the above payee (s) and for the respective amount listed.

I certify that the above claim is correct in accordance with the provisions of the Applicable Statute, that no part has been paid except as stated, that the balance is actually due, and that taxes from which the State is exempted are excluded.
➜

Signature in Ink Date

Title

State Comptroller's Pre-Audit

Verified

Audited

CERTIFIED FOR PAYMENT OF TOTAL AMOUNT

By

Expenditure				Liquidation			

* Please leave blank below this line.

Rev. August 2004	FAMILY CARE DIFFICULTY OF CARE AGENCY SPONSORED	Policy 10.8.4

Agency Sponsored Family Care (ASFC) is parallel to OMRDDs State Sponsored Family Care Program. The Family Care homes are certified in accordance with the same regulations and guidelines as the State Sponsored Program.

Effective June 1, 1994, OMRDDs Agency Sponsored Family Care providers became eligible to receive a monthly payment based upon the difficulty of caring for individuals in their home. These payments funded though Residential Habilitation under the Home and Community Services Based (HCBS) waiver, are in addition to the basic Supplemental Security Income (SSI-room and Board) payment, and are called "Difficulty of Care" (DOC) payments. Family Care providers receive a payment for all individuals living in their home regardless of the individual's eligibility from waiver or Medicaid services. Individuals who are not eligible to participate in the HCBS waiver are funded by the State.

Each ASFC provider is expected to develop a residential habilitation price proposal for approval by the DDSO that is in accordance with established guidelines for price calculation of residential habilitation services to individuals living in Family Care. Each proposal must include costs associated with both the program and the agency administration. The price must also include the Difficulty of Care (DOC) payment that is paid to the Family Care provider.

1. **22 Day Payment Rule:**

The DOC payment is a monthly payment in addition to Supplemental Security Income (SSI) room and board, calculated on daily services. A certified Family Care provider is entitled to a full month's payment as long as the individual has permanently resided in his or her home for at least 22 days and the provider has delivered services to that individual based on the Residential Habilitation Plan. If an individual is temporarily out of the home and the Family Care provider does not deliver 22 days of service, the payment will be prorated. The prorated payment is based on the number of days that the individual resided in the home and received residential habilitation services.

Exceptions to the 22-day payment rule include admission to:

i. Hospital.
ii. Intermediate Care Facilities (ICFs).
iii. Health Related Facilities (HRFs).
iv. Skilled Nursing Facilities (SNFs).

If an individual has been admitted to any of the above facilities during the month, the Difficulty of Care payment will be prorated.

If an individual moves to another Family Care home, on a permanent basis, the provider payment is prorated for the number of days services were provided. The provider is paid for the day of admission and not the day of discharge.

If the Family Care provider has delivered 22 days of Residential Habilitation Services during the month, and she requires emergency respite services, a full month's DOC payment will be made. The DOC payment will be adjusted and paid on a per day basis, utilizing the Off-Line payment process, if less than 22 days of Residential Habilitation Services have been delivered during the month.

II. **Trips Exceeding 30 Days**:

If a provider chooses, with the approval of the DDSO, to take individuals on a trip exceeding 30 days, and a monthly visit to the home cannot be made; the DDSO must discontinue making DOC payments to the Family Care provider.

If the Family Care provider makes a written request to continue DOC payments while on vacation, a written agreement must be in place with an agency or qualified professional in the field of mental retardation and developmental disabilities. The written agreement assures a visit(s) to the provider's temporary residence to verify that Residential Habilitation Services are being delivered in accordance with the individual's Residential Habilitation Plan developed from the Individualized Service Plan (ISP). This verification must be provided to the DDSO before a payment can be made.

The cost for verification is the responsibility of the Family Care provider. The DDSO staff may provide technical assistance or contacts in other states. **Under no circumstance will DOC checks be sent to an out-of-state address.**

III. **Individual Service Planning Model (ISPM)/Developmental Disabilities Profile-2:**

The DOC payment is determined by the Individual Service Planning Model (ISPM) Type of the individual residing in Family Care. The ISPM Type is generated from the Residential Developmental Disabilities Profile-2 (DDP-2) completed at the time the individual moves into Family Care. A Residential DDP-2 must be input into TABS for each individual **permanently placed** into Family Care for a computer-generated payment to be processed for state-sponsored Family Care providers.

The DDP-2 is reviewed and updated by the DDSO staff, and the Family Care provider on every two years. At the time of the review, changes may be made. If changes in the DDP-2 impact the ISPM type, the DOC payment level will change accordingly. The new reimbursement level will take effect in the month following the month that the change is

made. DDSO staff must exercise caution in the revision of the DDP-2 and must ensure that the information contained on the document accurately reflects the capabilities of the individual at that time. It is important to note that ***"changes** to the DDP-2 **do not necessarily impact** the ISPM type (payment) of the individual"*. It is the responsibility of the Family Care Home Liaison to inform the provider of any changes in the DOC payment prior to the effective date of the new payment.

Revisions to the DDP-2 may also be made if the needs of the individual change dramatically as a result of prolonged illness, hospitalization, or recuperation. In these instances the DDP-2 is reviewed to ensure that it accurately reflects the capabilities of the individual. It is also expected that a DDP-2 be revised when the individual recuperates from the illness.

IV. **The following two dimensions determine the ISPM Payment Levels:**

1. The DDP Adaptive and Health Scores are combined to estimate an individual's direct support level. In turn, the estimated direct support score is split into three direct support categories: *low, medium and high.*

2. The DDP Behavior Score predicts the frequency of behavior prevention and intervention. In turn, the behavior support level is split into two categories: *low and high.*

Since the ISPM types reflect all dimensions of an individual's challenges - adaptive, health and behavior- any change in these areas can cause a change in the ISPM type. However, to change an ISPM type the changes to the DDP must be significant enough to move an individual into a different *direct support category and/or behavior support category.*

The ISPM types were created so that approximately 25% of individuals would be *low direct support,* 50% would be medium, and 25% would be high. Behavior support categories were split so that approximately 25% of the individuals would be in the *high category*, and 75% in the *low.*

Each of these splits represents a doubling of support. For example, with each increase in the *direct support categories,* the estimated necessary direct support doubles. Similarly, the estimated frequency of behavior prevention and intervention doubles with the move from *low* to *high behavior supports.*

The following chart shows the six ISPM payment levels, created by splitting each direct support category by the levels of behavior support.

ISPM PAYMENT LEVELS		
ISPM TYPE 1	Low Direct Support/Low Behavior	$ 131.99
ISPM TYPE 2	Low Direct Support/High Behavior	$ 256.92
ISPM TYPE 3	Medium Direct Support/Low Behavior	$ 262.80
ISPM TYPE 4	Medium Direct Support/High Behavior	$388.32
ISPM TYPE 5	High Direct Support/Low Behavior	$ 762.57
ISPM TYPE 6	High Direct Support/High Behavior	$ 888.09

V. **Exceptional Circumstances Payments**:

There are limited circumstances in which a provider receives "exceptional circumstance" payments that exceed the DOC reimbursement generated by an individual's DDP-2. These payments are made with the approval of the Central Office Family Care Unit. The approval is granted for one year, at which time a review of the individual's needs is required. The exceptional circumstance payment is input into TABS, and is paid in the same manner as the regular DOC payment.

The approval process requires a current DDP-2, Individualized Service Plan, Residential Habilitation Plan, and a detailed clinical summary that describes the individual's health or medical or behavior needs. A psychological assessment and behavior plan will be required for any request due to any individual's challenging behaviors. The request must include the approval of the director or his or her designee.

The following items should be included in the calculation of a price and should not be paid by voucher by the DDSO:

1. Personal service and fringe costs for clinical staff such as a Family Care Home Liaison or a Registered Nurse. When possible, clinical services for individuals living in Family Care should be provided by generic service providers or accessed through a clinic.

2. Personal service and fringe costs for program and agency administration. This cost is subject to the screen of the approved historical agency administration percentage, if it is necessary to exceed the already approved limit, justification is required.

3. Costs of providing training to staff and Family Care providers.

4. Non personal service costs such as office supplies, utilities, staff travel, telephone, recruitment costs, and rent.

5. Costs of providing residential habilitation for each individual permanently placed in Family Care. Difficulty of Care payments also includes the cost of reimbursement for travel related to the delivery of Residential Habilitation services.

6. Costs of providing residential habilitation in those instances where the Family Care provider is unable to be present in the home as a result of employment. Substitute provider service must be a planned service and documented in the Individualized Service Plan (ISP) and a residential habilitation plan of each individual.

7. Costs associated with providing emergency respite services. It is recommended that the agency establish a "relief factor" cost by reviewing the historical costs of the program.

8. The Home Size Differential must be added to the rate based on the census of the ASFC program and the number of homes

9. The "Other" costs category must include the following: provider recognition, non-Medicaid funded medical costs, trial visits, retirement plaques, etc. These costs must be captured as "an add on" to the administrative and overhead portion of the price, and must not be included on a Charge Voucher.

There are other expenses in the operation of the Family Care Program that are NOT to be included in the price. They are as follows:

1. Room and Board payments for non-SSI eligible individuals will be made by the DDSO directly to the Family Care provider. It is the obligation of the sponsoring agency to ensure that the DDSO business office is aware of all necessary information to ensure that timely payments can be made.

2. Required immunizations will be funded by the DDSO in the same manner as for State Sponsored Family Care.

3. Assistive technology will be funded as an environmental modification (e-mods) or adaptive device as appropriate, and based on the availability of funds. The request must be made to the DDSO/NYCRO.

[redacted]

5. Damage claims will be routed through the DDSO and will be processed and paid in the same way as State Sponsored Family Care.

6. Medicaid Service Coordination for individuals who are enrolled in the waiver will be billed as a waiver service. For individuals that are not enrolled in the waiver, Comprehensive Case Management (CCM) should be continued. The costs should NOT be included in the costs of residential habilitation.

A Family Care provider may submit requests for damage reimbursement in any given fiscal year for any and all damages in that year to his or her personal or real property or the property of someone else. An individual with a developmental disability who was placed in the home by a sponsoring agency must have caused the damage. The sponsoring agency must be notified of the damage immediately. In an emergency, verbal approval for necessary repairs can be obtained. If the amount of the claim is for $2000 or less, a request for damage reimbursement must be submitted on *Form FCDR-1, Family Care Damage Reimbursement Request Form*, within 30 days from the date of the occurrence of damage.

In those instances in which the claim exceeds the $2000 limit, the FCDR-4 must be completed and accompany the FCDR1 within 30 days of the occurrence of the damage. Reimbursement for damages will be determined by the Office of Mental Retardation and Developmental Disabilities (OMRDD) and will be based on a review of the information submitted and the circumstances of the damage(s

RESPONSIBILITY	PROCEDURE
Family Care Provider	1. Notifies the Family Care Home Liaison of the damage on the same day, or the next business day. If an emergency exists, the Family Care Home Liaison, may request verbal approval from the DDSO Director or his or her designee, to make necessary repairs.
Family Care Home Liaison	2. Visits the Family Care home within five (5) business days of being advised of damage.
	3. Provides the Family Care provider with Form *FCDR-1, Family Care Damage Reimbursement Request Form* (ref. attached FCDR-1 or Form FCDR-4, as appropriate).
	4. Investigates damage(s) and completes Form *FCDR-2, Part 1, Investigation: Approval or Disapproval* incorporating recommendations, and signs the form.

Family Care Provider

5. Prepares reimbursement request form, following instructions on back of form.

   a. Completes, signs, and dates Form FCDR-1.

   b. Completes and signs *Form AC 92, Standard Voucher.*

   c. Obtains and attaches to the reimbursement request form, for damage a $1,000, and under, at least one estimate for repairs or a paid bill receipt. If estimate(s) is obtained by telephone, provides the name, address, and telephone number of the vendor(s).

   d. Obtains and attaches to reimbursement request form, for damage a $1,000, or more at least two estimates for repairs or a paid bill receipt.

   e. Ensures that all necessary attachments are completed accurately, all documents are included (estimate(s)/paid bill(s), a standard voucher, release), and ensures that a copy is maintained for the provider's file.

   f. Submits *Form FCDR-1, Family Care Damage Reimbursement Request* Form, to the Family Care Home Liaison within 30 calendar days following the event causing the damage.

6. Reviews, within five (5) business days *Form FCDR-1* and attachments for completeness and accuracy, and submits all originals of this information with *Form FCDR-2* to Family Care Coordinator or designee.

Family Care Coordinator or Designee

7. Within two (2) business days, reviews the information provided and approves or disapproves the request in space provided in Part II on Form FCDR-2. Submits all original documents to the Director or director's designee.

Director or Director's Designee	If the amount is less than $2000: Within five (5) business days, reviews the information provided, and approves or disapproves in the space provided on Part III on Form FCDR-2. Submits all original documents to the DDSO Business Officer. **OR**
	8(a) If the amount exceeds $2000: Within five (5) business days, reviews the information provided and approves or disapproves in the space provided on the Form FCDR-4 (Family Care Damage Reimbursement for claims exceeding the $2000/year ceiling) and forwards approvals.
	10. Maintains a record for each Family Care provider to determine the amount paid to the provider on an annual basis.
Bureau of Fiscal Services	11. Processes standard voucher by coding and sends to the Office of the State Comptroller for reimbursement.
Family Care Provider	12. Completes and signs *Form FCDR-3, Release*, upon receipt of payment.

FAMILY CARE
REQUEST FORM FCDR-1

Family Care Damage Reimbursement Request Form
FCDR-1

I, _____, residing at _____
_____, County of _____
State of New York, hereby present to the director or designee of the _____
DDSO, a damage claim reimbursement request in the sum of _____
($ _____) due to damage caused by an individual living in my home. The details constituting said damages are as follows (please include the date and circumstances under which damage occurred, the name of the individual causing damage, the age of any damaged items):

_____
_____
_____
_____
_____
_____
_____
_____

Signature of Family Care Provider _____ Date _____

Attachments: Estimates/Invoices/Receipts
Standard Voucher
Form FCDR-3, Release

FAMILY CARE

INSTRUCTIONS FORM FCDR-1

INSTRUCTIONS TO FAMILY CARE PROVIDER FOR SUBMITTING DAMAGE REIMBURSEMENT REQUEST FORM

1. Complete blanks on Form FCDR-1

   a. Type or print provider's name, street and town/city address, and county in which the Family Care home is located.

   b. Enter the name of the DDSO.

   c. Provide the amount of the claim, both in writing and in Arabic numbers.

2. Write a detailed description of the event that caused the damage, and the damage itself. Facts involved in the event must be set forth in sufficient detail to support the request for damage reimbursement.

3. Date and sign the form in the space provided at the bottom. Signature is to be the same as the name entered at the beginning of the form.

4. The actual damage must be specifically described, including the age and original cost of the damaged item(s).

5. Where repairs to damaged property have already been made, submit receipted bills or purchase receipts to substantiate the reimbursement request.

6. Where repairs to damaged property have not been made, submit itemized written estimates, which clearly show the labor charges broken down by estimated time and rate per hour, as follows:

   a. Damage/repair up to $1000: submit one itemized written estimate.

   b. Damage/repair more than $1000: submit two written estimates.

7. Complete Form AC 92, Standard Voucher.

8. Complete Form FCDR-3, Release.

9. Attach estimate(s)/invoices/paid bills/receipts, Standard Voucher, and Release to damage reimbursement request form.

10. Send all papers to Family Care Home Liaison (or other designated staff) within 30 days of the event that resulted in damage.

INSTRUCTIONS TO THE DDSO FOR PROCESSING DAMAGE REIMBURSEMENT REQUEST:

1. In accordance with OMRDD policies, each request is to be investigated. The results of the investigation are to be included on, or attached to Form FCDR-2, Approval/Disapproval of Family Care Damage Reimbursement Request, with each reviewer's recommendation or approval/disapproval.

2. Original copies of all forms and supporting document is to be submitted by the DDSO to:

   Office of Mental Retardation and Developmental Disabilities
   Bureau of Fiscal Services
   44 Holland Avenue Albany, New York 12229-0001

FAMILY CARE
DAMAGE REIMBURSEMENT REQUEST
INVESTIGATION
APPROVAL/DISAPPROVAL

PART 1: INVESTIGATION

SUMMARY (INVESTIGATION AND RECOMMENDATION (INCLUDING PLANS TO PREVENT FUTURE OCCURRENCE):

_____
_____
_____
_____
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_____
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_____

RECOMMENDATIONS:

_____
_____
_____
_____
_____
_____

Family Care Home Liaison _____ Date _____

FCDR -2

FAMILY CARE
INVESTIGATION
APPROVAL/DISAPPROVAL

PART II: FAMILY CARE COORDINATOR OR DESIGNEE

1. Approved ( ) Yes ( ) No Date _____ Family Care Coordinator/Designee _____

2. Disapproved ( ) Yes ( ) No Date _____ Family Care Coordinator/Designee_____

3. Rationale: _____

_____

_____

PART III: APPROVAL/DISAPPROVAL (Director or Designee completes the appropriate section):

A. Approved: I, _____, as Director or Designee of the _____ DDSO, have caused an investigation to be made of the facts in connection with the matter set forth on the attached Family Care Damage Reimbursement Request submitted by _____ Family Care Provider, residing at _____, and the damages resulting there from. I find that the facts constitute a just and reasonable reimbursement and, therefore, recommend reimbursement be made from the Family Care Appropriation.

Date _____ Director or Designee _____

B. Disapproved: I, as Director or Designee of the _____ DDSO, have caused an investigation to be made of the facts in accordance with the damage (s) at the home of _____ and do not approve reimbursement based on: _____

_____

_____

_____

Date _____ Director or Designee _____

FCDR-2

FAMILY CARE
OMR FORM FCDR - 3 RELEASE

I, _____, in consideration of the sum of _____ ($_____) to be in hand by the State of New York, the receipt whereof is hereby acknowledged, do for myself, my heirs, executors, administrators and assigns, releases and discharges the said State of New York, its officers, agents and employees from all damage request for reimbursement, claims, demands and liability of every kind and nature, legal or equitable, occasioned by or arising out of the facts set forth in the foregoing request, and in case any claim will have been filed by me with the Clerk of the Court of Claims for said damages at any time prior to the date of this release, I consent and stipulate that an order may be made by the Court of Claims without notice to me dismissing said claim upon the merits.

In witness whereof, I have hereunto set my hand and seal this_____ day of _____, in the year of _____ .

_____
(Family Care Provider)

(State of New York):
(County of _____)

On this _____ day of _____, in the year of _____, before me, the subscriber personally appeared _____ to me, known to be the person described in and who executed the foregoing release and she or he duly acknowledged to me that she or he executed the same.

_____
(Notary Public)

To be attached to Form FCDR - 1, Family Care Damage Reimbursement Form FCDR-3

Family Care Damage Reimbursement
(For Claims Exceeding $2000/yr Ceiling)

The Damage Claim described below for review and approval prior to contract preparation. The project is linked to specific damages caused by the individual to the Family Care provider personal or real property or the property of someone else.

DDSO: _____ Date: _____

Name of Provider: _____

Address of Home: _____

Mailing Address, if different: _____

City: _____ State _____ Zip Code _____ Tel _____

Home Owned? _____ Rented? _____ Leased? _____ No of Individual(s) _____

Individual(s) HCBS waiver Eligible? _____ # Non-HCBS waiver Eligible? _____

Description of Claim:

Cost Estimate Total: $ _____

DDSO Director or Designee Approval: _____ Tel: _______________

Date: _______________ Fax # _______________

Central Office Family Care Unit Approval: _____ Date: _______________

OMRDD Budget Office Approval: _____ Date: _______________

Returned Form FCDR-4 with Action to DDSO: Date: _______________

Returned Form FCDR-4 without Action. Please provide the following: The request to exceed the $2000 limit was not approved:

_____

_____

Each Family Care provider may receive emergency respite services as a result of:

1. A death in the immediate family of the provider.

2. Serious illness or injury to the provider.

3. Serious illness or injury to a member of the provider's immediate family.

4. Emotional instability or severe stress of the provider.

5. Serious illness or injury to an individual with a developmental disability living in the Family Care home.

These payments are available when the provider is unable to access natural supports within their family. In instances which require that emergency respite be delivered for more than five days (5) in a thirty day (30) period, it is the responsibility of the Family Care Home Liaison (FCHL) to review the specific situation with the Sponsoring Agency Family Care Coordinator/designee, and the Medicaid Service Coordinator, where applicable, prior to the director or his or her designee's authorization of additional respite.

The purpose of this review is to determine if additional emergency respite service is in the best interest of the individual (s), and if respite service will be discontinued in a reasonable period of time. In those instances where emergency service must continue for thirty (30) days or more, the Sponsoring Agency Family Care staff, in conjunction with the director or his or her designee, must consider the possibility of relocating the individual(s) to another Family Care home. If another home is selected, the monthly Supplemental Security Income (SSI) payment must be adjusted and used to reimburse the Family Care provider.

Emergency respite service must be provided with as little disruption to the individual (s) as possible. In arranging for emergency respite service, consideration will be given to provision of service in hourly segments during peak care times in the early morning and early evening hours.

To assure an individual's well-being while she or he is being cared for by a substitute provider, the Sponsoring Agency Family Care staff, must visit the individual within the home in which respite service is being provided during each five (5) day period throughout the respite duration.

When an individual is being discharged from a hospital or other medical facility due to an illness or surgery and is in need of additional supports and services prior to resuming normal activity, the sponsoring agency in conjunction with the discharging facility must first consider returning the individual to his or her Family Care home.

A hospital discharge meeting, involving the individual (if possible), family member, advocate, the Family Care provider, Family Care Home Liaison, Medicaid Service Coordinator, clinical team, and hospital representative(s) must be held to discuss the services that will be required, and the viability of providing the services in the Family Care home. A decision to return the individual to the Family Care home must address the issue of safety, accessibility, willingness and ability of the provider to provide needed services, and resource availability (nursing, environmental modifications, adaptive technology, etc). All needed services must be in place prior to the individual being discharged to the Family Care home.

Reimbursement:

1. The Family Care Home Liaison or the Family Care provider must contact the Sponsoring Agency Family Care Coordinator/designee as soon as it is known that emergency respite is needed. At that time, payment options and procedures must be reviewed so that the Family Care Home Liaison can inform the Family Care provider of approximately what will be paid. The Family Care Home Liaison then sends written justification with documentation, if necessary, or an E-MAIL to the Family Care Coordinator or designee, with a copy to the Medicaid Service Coordinator, summarizing the circumstances requiring emergency respite, to include the projected cost, and the amount of time required.

2. If emergency respite exceeds five (5) days, the Family Care Home Liaison must contact the Family Care Coordinator or designee at the end of each five (5) day period to review the situation, calculate the costs incurred to date as well as projected costs.

   Each review must be followed up with a written or E-MAIL summary to the Family Care Coordinator or designee who will then notify appropriate staff.

3. A full day rate (for *16 - 24 hours* of respite) is based on the number of individuals in the home. For respite less than *16 hours,* the reimbursement rate will be at the federal minimum wage rate up to $10.00 per hour. The hourly payment cannot exceed the full day rate of payment.

PAYMENT SCHEDULE

FULL DAY	# OF INDIVIDUALS
$ 50	1
$ 90	2
$120	3
$150	4 OR MORE

4. When respite service is provided at a community residence, the level of payment to the residence is in accordance with the amount the community residence charges.

5. Payment is made to the approved substitute provider (ref. Policy 10.4.4 Approved Substitute Provider) who must file the appropriate vouchers including his or her Social Security number. An approved substitute provider may include members of the certified provider's family, including adult children age 18 or older living in the home. If the substitute provider is living outside the home, the person must be age 21 or older. Exception, the substitute provider may be approved at the age of 18 if they have experience and training in human services, such as a college student matriculating in nursing, social work, psychology, physical therapy, occupational therapy or special education. The spouse or significant other is not eligible to receive reimbursement for providing emergency respite services.

6. The information required on the voucher must include the name and address of the person rendering the respite service, the name of the Family Care provider receiving services, the name (s) of the individual(s) residing in the home, the date(s) on which the services were performed, and the payment due for the services provided. A Family Care provider must not advance money to the approved substitute provider or certified Family Care provider. The respite services are to be paid directly to the substitute provider by the sponsoring agency.

7. Multiple vouchers may be submitted during the period of respite. It is recommended for State-Sponsored Family Care that vouchers do not exceed $1000 so that they may be reimbursed on the State Quick Pay process. Generally, under Quick Pay, reimbursement is made within ten (10) business days of receipts of all required documents.

EMERGENCY RESPITE PROCEDURES

Form 245 **Sponsoring Agency** _____

Substitute Provider (Pay to)	**Family Care Provider**
Name _____	Name _____
Address _____	Address _____
_____	_____
SS. No. _____	SS. No. _____

Respite was provided ____ in, outside of the individual(s) Family Care home for the following reason(s):

_____

_____

_____

_____

_____

Individual's (s) Names _____, _____,

_____, _____,

_____, _____.

_____, _____

Amount owed substitute provider $_____ for _____ days at _____ per day.

$_____ for _____ hours at _____ per hour.

I certify that the payee as stated provided emergency respite service:

SubstituteProvider	Date
Family Care Provider	Date
Family Care Coordinator/Designee	Date
Director or Designee Signature	Date

cc. Provider File

Eliot Spitzer
Governor

Diana Jones Ritter
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
44 HOLLAND AVENUE
ALBANY, NEW YORK 12229-0001
(518) 473-1997 • TDD (518) 474-3694
www.omr.state.ny.us

TO: DDSO Directors
DDSO Family Care Coordinators
ASFC Executive Directors

FROM: Joyce Cloutier, Statewide Family Care Coordinator

DATE: January 15, 2008

SUBJECT: Family Care Home Differential

Attached please find a revised Policy 10.8.2. The payment amounts have not changed; the policy clarifies how an ASFC agency may pay the "Home Size Differential Payment/Supplement."

If you have any questions, please contact Joyce Cloutier at (518) 473-6255.

JC/ka

Attachment
c: S. Smits
K. Broderick
J. Steven
A. Coleman
B. O'Neil

	FAMILY CARE HOME SIZE DIFFERENTIAL	
Rev. January, 2008	(supplement)	Policy 10.8.2

Each state-sponsored Family Care provider will receive a semi-annual home size differential (supplement) payment based on the number of individuals permanently placed in their home. The payment is typically included in the Difficulty of Care check received in March and October.

If a provider receives a payment for an individual who subsequently leaves the home, DDSO staff will not ask for the return of any portion of the home size differential payment. However, if an individual is placed in the home after the home size differential payment is made, the provider will not be eligible for this payment until the next scheduled payment run that includes the home size differential payment.

Agency sponsored family care agencies may choose to make these payments to providers monthly or semi-annually.

The payment amounts are:

Number of Individuals	Amount of Supplement	Semi-Annual
1	$ 900	$450
2	$1220	$610
3	$1340	$670
4	$1460	$730

Rev. August 2004	FAMILY CARE PAYMENT FOR SUBSTITUTE PROVIDER SERVICE	Policy 10.8.7

Payment for substitute provider service may be up to 60 hours per month. The payment rate, as of the date of issuance of this policy, is up to $8.00 per hour as determined by the sponsoring agency. Approval is at the discretion of the sponsoring agency Family Care Coordinator or designee, and will be based on a recommendation from the appropriate Family Care Home Liaison as well as on the availability of funds at the sponsoring agency. The sponsoring agency may approve substitute service payments up to $10.00 per hour if it has been determined that the individuals living in the home require specialized care. A higher payment may be approved if the following conditions are met:

1. At least two individuals are being cared for by the approved substitute provider, and

2. Those individuals must require special hands on care and assistance that would include:

    a. Specialized feeding techniques.
    b. Use of mechanical lifts.
    c. Alzheimer's/Dementia care.
    d. An individual that requires the skills of a trained para-professional such as a certified nurses aide or a licensed practical nurse, or
    e. An individual with challenging behavior needs.

Family Care providers with individuals who no longer attend day activity or who have a limited or reduced day activity schedule may request up to twenty (20) hours of substitute service for each month that the individual(s) does not attend a day activity or attends on a part time basis. The request does not require that the provider justify the use of substitute services.

The Family Care provider must submit a written request on *Form FC-SS-1 Application for Substitute Services* (see attached) to the Family Care Home Liaison in sufficient time to obtain approval prior to the need for substitute service. Verification of employment *must* be done on at least an annual basis and maintained in the provider's file. Payment for substitute service cannot be made to spouses or significant others living in the Family Care home.

The substitute provider, if living in the home, must be at least 18. If the respite provider is living outside the Family Care home the person must be age 21 or older. Exception, the respite provider may be approved to provide respite at the age of 18 if they have experience and training in human services (i.e., College student matriculating in nursing, social work, psychology, pt., ot., special education). Training requirements for sitters are found in *Policy 10.4.* The substitute provider must submit requests for payment in a timely manner.

Payment for Substitute Provider Services (see attached). This form must have the signature of the Family Care provider and substitute provider. All payments for substitute provider service will be made directly to the substitute provider. Exceptions to this procedure will require the approval of the Family Care Coordinator and Sponsoring Agency Director or designee. Request for substitute service payments must be processed by the sponsoring agency on at least a monthly basis.

Family Care providers are eligible for substitute provider services, *under the following circumstances when:*

1. After an individual's day activities end, that individual would be home alone because the Family Care provider must be at his or her place of employment outside the home at that time.

2. A provider must leave for their place of employment prior to the time the individual(s) leaves for their day activity and that individual would be home alone.

3. A provider's employment takes place nights or weekends when the individual would normally be home.

4. An individual no longer attends a day activity on less than a full time basis.

5. A provider visits an individual who has been hospitalized at the request of the sponsoring agency or the hospital, and the individuals remaining in the home are unable to or choose not to visit the individual who has been hospitalized.

6. A provider with the approval of the sponsoring agency is required to attend to the needs of a hospitalized individual. Provider related expenditures can be reimbursed with appropriate documentation.

Please note that substitute provider services are separate from regular Family Care respite payments offered under emergency respite, and are not considered an entitlement.

OMR Form FC-SS-1 **APPLICATION FOR SUBSTITUTE PROVIDER SERVICES**

Sponsoring Agency _____ Date _____

Provider's Name _____ Address _____

_____ Zip Code _____ Tel. # _____

Individual(s) _____

_____

Hourly Rate _____ Hours Needed Per Week _____ Expected Duration _____

Hourly Rate x Hours Needed Per Week x Number of Weeks _____ = $ _____

Projected Annualized Cost $ _____

The following is the rationale for my need for Substitute Provider Service based on *Family Care Manual 10.8.7:*

Employer _____, Address _____

Contact Person _____, Tel. # _____

Work Week Schedule _____

Individual(s) Program\School Schedule _____

_____

_____

Signature Family Care Provider _____ Date _____

As the Family Care Home Liaison, I have reviewed the request for Substitute Services submitted by the above named Family Care Provider. After verification of employment or hospitalization of an individual living in the home, I find this request to be valid and reasonable. I therefore recommend payment be made from the *Family Care Appropriation*, if funds are available.

Signature _____ _____
Family Care Home Liaison — Date of Approval/Disapproval

Signature _____ _____
Family Care Coordinator/Designee — Date of Approval/Disapproval

Signature _____ _____
Director or Designee — Date of Approval/Disapproval

Comment(s)

_____

_____

_____

_____

_____

Original: Family Care Provider File
Copy: Family Care Coordinator/Designee

OMR FORM FC-SS

PAYMENT FOR SUBSTITUTE PROVIDER SERVICES

SUBSTITUTE PROVIDER INFORMATION

Name _____

Address _____

_____

FAMILY CARE PROVIDER

Name _____

Address _____

Payee/Substitute Provider SS # _____ Provider SS # _____

County _____ Individuals residing in home _____ Dates of Service _____ thru _____

Dates Must coincide with Payment Schedule. Total Number of Hours May Not exceed 60 per month.

DATE OF SERVICE	HOURS		TOTAL HOURS
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	

DATE OF SERVICE	HOURS		TOTAL HOURS
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	
	:	:	

I attest that the above hours of service were provided and I am entitled to payment.

_____ / _____
Substitute Provider Signature Date

I have reviewed and certify that the above hours of service were provided and payment is due.

_____ / _____
Family Care Provider Signature Date

_____ (# HOURS) X $ _____ (RATE/HR) = $ _____ GRAND TOTAL

APPROVED BY: Family Care Home Liaison _____ Date _____

As Family Care Coordinator/Designee, I have reviewed the above request and I certify that a Substitute Provider Agreement is on file and the substitute provider is entitled to payment at the above stated rate.

_____ / _____
Family Care Coordinator/Designee Date

_____ / _____
Team Leader (Optional) Date

Copies: (Original- Business Office) (Gold-Provider's Record) (Yellow -Sitter) (Pink –Family Care Provider)

FAMILY CARE
RECRUITMENT STIPEND
(FINDER'S FEE)

Rev. January 2008 **10.8.8**

To encourage the growth of OMRDD's Family Care Program, an OMRDD certified Family Care provider may receive a $200.00 stipend for recruiting a prospective provider when that provider becomes certified. The stipend will be paid after the prospective provider receives an operating certificate. Sponsoring agency staff are not eligible to receive this stipend.

STATE-SPONSORED PROGRAMS:

To receive this payment, the *Family Care Recruitment Stipend form (FC-RS-1)* must be completed by the referring provider. The Family Care Coordinator must verify the information on the form, sign the form, and attach a completed *Standard Voucher (Form AC 92)* for processing by the Business Office. **Object code** number **64608** must be used on the voucher. Stipend payments must be reported as gross income; an "**N**" must be entered in the IRS code box.

AGENCY SPONSORED FAMILY CARE PROGRAMS:

Agency sponsored Family Care agencies are responsible for paying this stipend for referrals made by their certified providers. This cost should be included in the agency residential habilitation price. The *Family Care Recruitment Stipend form* must be completed by the referring provider, with the Family Care Coordinator verifying information before processing. The stipend payment must be reported as gross income.

FAMILY CARE RECRUITMENT STIPEND

RECRUITING PROVIDER INFORMATION:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____-_____

County: _____ Telephone Number ( ) _____

RECRUITED PROVIDER INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____-_____

County: _____ Telephone Number ( ) _____

I recruited the above named provider applicant and am hereby requesting payment of the stipend upon the applicant's certification as a Family Care Provider.

_____ _____

Signature Date

FAMILY CARE COORDINATOR'S USE ONLY

Information verified: Yes _____ No _____

Operating Certificate Number of newly certified provider: _____

_____ _____

Signature Date

Date Form and Voucher submitted to Business Office: _____

Individuals living in Family Care are entitled to periods of therapeutic leave from the Family Care home for programmatic, recreational, social or medical purposes. It is expected that during this period of therapeutic leave the Family Care home will continue to be the individual's primary residence. The Family Care provider will remain available to deliver services and reserve living accommodations for the individual within the Family Care home.

Other than medical purposes, periods of therapeutic leave are temporary in nature and will usually not exceed *30 days* in duration. If it is necessary for an individual to be away from the Family Care home for therapeutic leave, it is the responsibility of the Family Care provider to notify the Family Care Home Liaison who will notify the Medicaid Service Coordinator and other appropriate staff. The need for review and approval of therapeutic leave is as follows:

1. Therapeutic leave to a hospital or another residential setting must always be reviewed and approved by the team with documentation in the individual's record stating that such "temporary" or "time-limited" admission represents the most appropriate location where the individual's needs can be met.

2. Therapeutic leave of *90 days'* duration or less must be reviewed and approved by the Family Care Coordinator or designee.

3. Therapeutic leave for medical purposes may be up to *90 days,* and must be reviewed and approved by the team and must meet the following criteria:

    a. A physician certifies that he or she expects the individual to be medically confined for *90* full consecutive days or less.

    b. The physician's certification must be prepared and dated no later than *10* calendar days of the month following the close of the month of admission.

    c. The Revenue Support Field Officer must submit the evidence of certification to Social Security Administration (SSA) no later than the *10th* calendar day of the month following the close of the month of admission to another residential setting.

    d. The provider, individual or Family Care Home Liaison, on behalf of the individual, must demonstrate that she or he needs to pay expenses of maintaining the living arrangement to which he or she must return.

    e. Evidence required to establish this need must be provided to the Revenue Support Field Officer no later than *10* calendar days after the close of the month of admission.

Individuals being considered to live in Family Care or move from one Family Care home to another have the opportunity to have one or more trial visits in the prospective home. The total number of consecutive days allotted for trial visits to a specific family may not exceed *fourteen days (14)* unless specific written approval is given by the sponsoring agency director or his or her designee.

Family Care providers will be allowed a per diem rate for each day care is provided. The per diem rate is equal to the monthly Supplemental Security Income (SSI) Congregate Care Level "I" Provider Payment, plus the individual's Difficulty of Care payment level, which is based on the most current Residential Developmental Disabilities Profile-2, divided by 30 days. Family Care providers are not eligible to receive reimbursement for residential habilitation services or difficulty of care payment for persons placed on trial visits.

Providers that deliver 8 hours or more of care will receive the full per diem amount. When 1 – 8 hours of care is provided during a trial visit, the rate of payment will be paid at half the per diem. Expenses for trial visits are reimbursed through the sponsoring agency's Family Care Appropriation or the residential habilitation price.

Personal spending money is to be provided to prospective individuals during trial visits to enable them to participate in activities. Personal spending money is to be provided from an individual's personal funds if the individual is residing in a certified Family Care home or by the individual's family if the individual resides elsewhere in the community. If the individual resides in a sponsoring agency Family Care Program and does not have sufficient personal funds, the provider will be reimbursed through the Family Care account for a sum not to exceed *$8.00 per diem* for a *fourteen (14) day* period.

	FAMILY CARE **RESPITE SERVICE IN FAMILY CARE HOMES FOR FAMILIES IN THE COMMUNITY**	
Rev. December 2000		**Policy 10.8.11**

Respite services for families may be provided in certified Family Care homes or the homes of respite sitters approved by the sponsoring agency. A family's use of respite services is limited to forty-two (42) overnights per individual annually. A single respite stay must not exceed thirty (30) consecutive days. Only in emergency situations may respite be provided without preplanning. In emergency situations, the Family Care provider must contact the Family Care Home Liaison (FCHL) to inform him or her that an emergency stay has been requested.

The FCHL must notify the Medicaid Service Coordinator of an emergency stay. If the Family Care provider is unable to reach the FCHL, the administrator on-call (AOC) must be notified and must authorize the respite stay. Once contacted, the FCHL must ensure that the Medicaid Service Coordinator completes all necessary documentation. Emergency respite must be done in accordance with the guidelines outlined in Policy 10.8.6 - *Emergency Respite Services.*

In accepting the individual for either overnight or hourly respite, the certified capacity of the Family Care home, as specified on the operating certificate, cannot be exceeded. Overnight for families must be provided in a vacant certified bed. The bed of an individual permanently living in Family Care but who is temporarily absent from the home **cannot be used for respite.**

The Family Care provider or approved respite sitter will be reimbursed from *Family Support* funds, by the sponsoring agency in accordance with the payment guidelines provided for in Policy 10.8.6 *Emergency Respite Procedures.* The rules governing the provision of respite (preplanned or emergency) for families are as follows:

RESPONSIBILITY	PROCEDURE
Medicaid Service Coordinator/Sponsoring Agency Designee	1. Ensures that the individual has a developmental disability as defined by *Section 1.03 (22)* of the *Mental Hygiene Law.*
	2. Enrolls the family and registers the individual for respite services using *Form OMR 726, Family Care Respite Services for Families-Registration (Form 726 Optional).*

3. Ensures, by contacting the Family Care Home Liaison, that the certified capacity of the home is not exceeded.

4. Ensures, by contacting the Family Care Home Liaison, that the bed of an individual permanently placed in the home but who is temporarily absent from the home is **not used.**

5. Obtains information on, health status (e.g., TB, Flu, Hepatitis B-appropriate immunization) routine and special needs of the individual, including information on his or her medical and dental regimen, allergies, special diet/nutritional needs, and/or current behavior problems.

6. Reviews the individual's health status and special needs with the respite provider prior to service provision.

7. Ensures that an adequate amount of medication has been provided, by the family, in its original container, and the provider receives insurance cards.

8. Ensures that the Family Care provider receives a written plan of the care and interventions normally performed by the family that will be continued by the Family Care provider. The following areas of service must be considered: personal hygiene, behavior management, and transportation.

9. Obtains the name and telephone number of the individual's primary care physician and any other significant health care professionals, such as an allergist, psychologist.

10. Obtains the name and telephone number of family members, as well as someone to call in an emergency, if the family cannot be reached.

11. Obtains a written statement authorizing the Family Care provider to administer medication to the individual and to seek medical care should all family members be unavailable. The authorization must include a written start and termination date, which may be up to one year.

12. Maintains records for those families who receive respite services. These records must include:

    i. Registration form and other information about the family and the individual who will be staying with the Family Care provider.

    ii. Documentation of the individual's physical examination.

    iii. The original copy of any authorization received.

    iv. Documentation of the total amount of respite provided to the family, both hourly and overnight.

v. Documentation of special services provided, events that occurred, or special problems or needs that could not be met by the Family Care provider

13. Maintains an updated record of those certified or approved respite beds in Family Care homes that are available for respite for families.

14. Ensures the completion, processing and filing of *OMR Form 726, Family Care Respite Services for Families-Registration and Form OMR 726 SR, Family Care Respite Services for Families-Service reporting (Form 726 Optional).*

15. Provides, in conjunction with the family, the necessary information about the individual who is to receive respite and the service reporting forms for reimbursement to the Family Care provider when a respite bed is to be provided.

16. At the end of each month, ensures that all *OMR 726 SR* forms are signed and sent, in a timely manner, to the DDSO Business Office for processing (Form 726 SR Optional).

17. Ensures that a copy of each form is placed in each individual's file that is maintained by the service coordinator.

Family Care Provider

18. Obtains medication in its original container, as well as telephone numbers of a family member and/or a family friend who may be contacted in an emergency.

19. Provides room and board, supervision and other services as necessary.

20. Notifies the service coordinator, sponsoring agency, and family of any emergency needs or problems.

21. Agrees to oversee the spending of any personal allowance during the respite stay.

Individual's Family

22. Provides the Family Care provider or respite sitter with sufficient clothing, personal allowance, medication, telephone numbers, insurance cards, and plan outlining the individual's daily routines.

23. Provides or arranges, if necessary, transportation to the Family Care home, school or other programs during the respite stay.

Medicaid Service Coordinator

24. Ensures that the individual is transported to and from the respite site and other programs during the respite stay.

25. Arranges, in conjunction with the Medicaid Service Coordinator, an alternate residential site, if the individual is unable to return home.

State of New York Office of Mental Retardation and Developmental Disabilities OMR-Form 726 Revised 12/00	RESPITE SERVICE IN FAMILY CARE HOMES FOR FAMILIES IN THE COMMUNITY

PURPOSE:: REGISTRATION CORRECTION UPDATE

1. "TABS" No. (If Known) _____

2. Sponsoring Agency Name 3. DDSO _____

Individual's Name/Address

_____
(Last, First, MI)

5. Date of Birth ____/____/____
Month Date Year

6. Sex Male Female

_____
No Street

_____
City State Zip Code

7. Type of Residence Living with Relative Friend

8. Social Security No. _____

9. Parent, Legal Guardian, Advocate or Correspondent Name/Address

_____
(Last, First, MI)

_____
No. Street

_____
City State Zip Code

( )
Telephone No.

_____
Relationship

==========

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

==========

Distribution:
Original -FC Respite Services for Families
Administrative Record

10. Significant Disabilities (Check all that apply)

1. Mental Retardation
2. Autism
3. Cerebral Palsy
4. Epilepsy
5. Neurological Impairment(e.g., Tourettes Syndrome, Prader-Willi, Learning Disabilities)
6. Psychiatric Disability
7. Physical/Medical Conditions (e.g.,Cardiovascular, Blood Diseases, Respiratory)
8. Sensory Impairment (e.g., vision, hearing)
9. Undetermined

11. Primary Physician

_____

Telephone No. _____

_____

12. Health Insurance Holder

_____

Policy No. _____

13. Medicaid No. _____

14. Form Completed by

Signature _____

Title _____

15. Date:____/____/____

16. Data Entered by _____

INSTRUCTIONS FOR COMPLETING REGISTRATION FORM (OMR 726)

This form records data for Family Care Respite Services for Families Registration and may also be used for correcting and updating information.

PURPOSE

Check the appropriate box on the top of the form:

REGISTRATION: acceptance of an individual for Family Care Respite Service for Families Program.

CORRECTION: change in information entered previously.

UPDATE: the entering of more current information about the individual.

ITEMS;

1. TABS Number - or other identifying number as assigned by sponsoring agency/number created by OMRDD "TABS" system; if unknown, leave this area blank.
2. Sponsoring Agency Name - voluntary agency or DDSO Sponsoring family care homes.
3. DDSO Name - if sponsoring agency is a voluntary agency, enter responsible DDSO.
4. Individual's Name/Address - individual's name and address at the time of the initial contact.
5. Date of Birth - enter numbers for month/date/year. If unknown, estimate the date of birth by using zeros for the month and day and entering the year.
6. Sex - check appropriate box.
7. Type of Residence. Living with relative or friend.
8. Social Security Number - Social Security number of the individual who will occupy a respite bed in a Family Care Home.
9. Parental/Legal Guardian, Advocate, or Correspondent - fill out information as requested, printing or writing clearly. Under "relationship" write or print information in the space provided.
10. Significant Disabilities - mark all that apply.
11. Primary Physician - enter name and telephone number of primary physician.
12. Health Insurance Holder - enter name of health insurance policy holder and the policy number, if applicable.
13. Medicaid Number - enter individual's Medicaid number, if applicable.
14. Form Completed By- signature, complete title, date and telephone number of the Medicaid Service Coordinator or someone responsible for accuracy of the registration information; date registration was completed.
15. Date Data entered.
16. Data Entered by - is to be completed by the DDSO data entry operator.

Distribution

1. Retain original for Family Care Respite Services for Families-Administrative Record.

State of New York Office of Mental Retardation and Developmental Disabilities OMR-Form 726 SR Revised 12/00	RESPITE SERVICE IN FAMILY CARE HOMES FOR FAMILIES IN THE COMMUNITY

PART 1 MONTH: YEAR:

1."TABS" Number (if known)	2. Sponsoring Agency	3. DDSO

4. Individual's Name/Address (Last, First, MI)	5. Date of Birth / / Month Day Year	6. Sex Male Female
No. Street City State Zip Code	7. Registration Date / / Month Day Year	8. Social Security No.
9. Type of Residence : Living with Relative Friend	10. Date of Last Physical Examination / /	11. Medicaid No.

12. Family Care Provider Name/Address (Last, First, MI) No. Street City State Zip Code ( ) Telephone No. 13. Type of Residence: Living with Relative Friend	14. Parent, Legal Guardian, Advocate or Correspondent Name/Address (Last, First, MI) No. Street City State Zip Code ( ) Telephone No. Relationship

PART II

15. Period of Respite Month _____ Year _____

Date Begin	Time Begin	Date End	Time End	Number of Hours
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
0.				

16. Form Completed by: Signature/Title ( ) Date / / Telephone No. Month Day Year	17. Date Data Entered / / Month Day Year	18. Data Entered by: Signature Title

19. The Business Office is Authorized to Pay the Above Named Family Care Provider $ _____ for Respite Services Provided to the Individual Indicated.

Signature/Title _____ Telephone ( ) _____ Date / /

Distribution: Original - Business Office Pink Copy - FSS Record Gold Copy - FC File

INSTRUCTIONS FOR COMPLETING
FAMILY CARE RESPITE SERVICES FOR FAMILIES - SERVICE REPORTING FORM (OMR 726SR)

This form records data for actual respite stays in a given calendar month.

A. Instructions

Part I

1. TABS" Number - or other identifying number as assigned by the sponsoring agency/number created by the OMRDD"TABS" system; if unknown, leave this area blank.

2. Sponsoring Agency Name - voluntary agency or DDSO Sponsoring family care homes.

3. DDSO Name - if sponsoring agency is a voluntary agency enter responsible DDSO.

4. Individual's Name/Address - name and address of the individual occupying the respite bed at the time of the initial respite stay in the calendar month.

5. Date of Birth - enter numbers for month/day/year. If unknown, estimate the date of birth by using zeros for the month and day and entering the year.

6. Sex - check appropriate box.

7. Registration Date - the date on which registration occurred (OMR726 was completed).

8. Social Security Number - the Social Security number of the individual occupying the respite bed in the family care home.

9. Type of Residence. Living with relative or friend.

10. Date of Last Physical Examination - at time of initial stay in the calendar month.

11. Medicaid Number - individual's Medicaid number, if applicable.

12. Family Care Provider Name/Address - enter name of family care provider, address and telephone number.

13. Type of Residence. Living with relative or friend.

14. Parent/Legal Guardian/Advocate or Correspondent - fill out information as requested, printing or writing clearly, under "relationship" write or print information in the space provided.

PART II

15. Period of Respite - for each separate respite stay:

    a. Enter the date and time the respite stay began in Date Began and Time of Day Column.
    b. Enter the date and time respite stay ended in Date End and Time End Column.
    c. Calculate the total number of hours of the respite stay and enter this number in the Number of Hours column.

16. Form Completed By/Date Completed - signature, complete title and telephone number of the Medicaid Service Coordinator or someone responsible for accuracy of the recorded respite stays and the date the form is completed at the end of the calendar month.

17. Date Data Entered.

18. Data Entered by____ is to be completed by the Sponsoring Agency Data Entry Staff.

19. Calculate Payment - Authorized payment by Business Office with signature, title, telephone number, and date. Send original to appropriate DDSO Business Office; pink copy to Family Support File and gold copy

State of New York Office of Mental Retardation and Developmental Disabilities OMR-726 L Revised 12/00	FAMILY CARE RESPITE SERVICE FOR FAMILIES PROVIDER LOG
Provider:	DDSO:

SERVICE MONTH/YEAR

INDIVIDUAL Last, First, Name	**DATE BEGAN**	**TIME OF DAY** (AM/PM)	**DAT E ENDED**	**TIME OF DAY** (AM/PM)

Distribution: Original - Business Office Pink Copy - FSS Gold Copy - Family Care Provider File

Rev. July 2003	FAMILY CARE EDUCATIONAL RESPITE	Policy 10.8.12

A Family Care provider may, based on the availability of funding, request educational respite services when the provider attends training required by the sponsoring agency or the provider attends workshops, seminars, conferences or other training that benefit both the provider and the individual(s) needs.

A provider may receive educational respite services under the following circumstances:

1. The provider needs the training for recertification.
2. The training meets the needs of the individual(s).
3. Training cannot be provided during a time when the individual(s) are at work, program, and/or have other supervision available.
4. The substitute provider is prior approved by the sponsoring agency in accordance with Family Care Policy 10.4.4.
5. The training is prior approved by the Family Care Coordinator or his or her designee.
6. The rate of reimbursement is based on the same rate(s) outlined in the Substitute Provider Policy and is based on the express needs of the individual(s).
7. The approved substitute provider, on the revised Form 245, submits the request for payment.
8. The payment is made directly to the substitute provider.

SECTION 10.9

PROVIDER SUPPORT

10.9.1 Supporting Providers

10.9.2 Provider Recognition

Family Care providers are private parties certified by the Office of Mental Retardation and Developmental Disabilities, to provide supervised residential services in their homes for individuals with developmental disabilities. The responsibilities of Family Care providers are clearly outlined in New York Codes, Rules and Regulations (14 NYCRR) Part 687 and this manual. The policies recognize that the residential habilitation service delivered by providers is an essential part of each Individual Service Plan (ISP), and that the provider is a crucial member of the team. As a member of this team each provider is entitled to the same respect and professional courtesy offered to any other team member.

In their capacity as certified Family Care providers, a provider will:

1. Receive comprehensive information on any individual referred to their home prior to finalizing the living arrangement.

2. Have, based upon his or her ability to serve that individual, without a penalty the opportunity to accept or deny admittance to each individual being referred.

3. Participate in orientation programs, regular in service training, and ongoing training made available through the sponsoring agency.

4. Receive prior notification, attend, and participate in appropriate planning meetings concerning individuals in their homes.

5. Receive prompt notification of any changes in OMRDD policy affecting Family Care, and be provided with a copy of the Family Care Manual.

6. Receive updated copies of 14 NYCRR Parts 687, 624, 633, Section 635-7.4 and the Family Care Manual.

7. Receive information on provider payments or individual entitlements.

8. Receive clinical and administrative support needed to maintain the individual(s) in the community.

9. Have ready access to sponsoring agency staff in order to discuss decisions or actions they believe unfairly affect the home or individuals in the home.

10. Have representation on the Sponsoring Agency Family Care Advisory Council to address issues and concerns.

11. Keep all records, including the identity of the individual confidential. **NOTE**: A Family Care provider's records not relating to an individual receiving service may be considered business records and therefore not confidential.

12. Receive the same respect, support and consideration as any professional or para-professional staff.

13. Be provided with reasonable notice of announced visits, cancellations, meetings, and notification when there is an incident or allegation of abuse in the individual's day program, etc.

14. Not be presumed to have violated any regulations or policies until the completion of an investigation and presentation of findings. The Commissioner, however, reserves the right to temporarily suspend an operating certificate if she or he has reasonable cause to believe that at the time of a temporary suspension of the operating certificate, the health or safety of the individual receiving service is in imminent danger.

15. Be treated by DDSO staff in a manner that assures personal, legal, and civil rights.

16. Be treated in a way that acknowledges, and respects their religion, race, cultural diversity, age, and sex.

17. Be treated as a responsible adult.

Sponsoring agencies are to ensure that these statements provide the foundation for the working relationships between Family Care providers and Family Care Program staff. The Family Care staff is expected to communicate clearly, and promptly with Family Care providers around issues affecting the certification/recertification of the home or individuals in the home. Providers are expected to communicate in a like manner, and to inform the Family Care Coordinator or other appropriate DDSO staff of any infringement of this policy.

RESPONSIBILITY:

Sponsoring Agency
Family Care Coordinator

PROCEDURE:

1. Ensures that implementation of Policy 10.9.1. is included in all agency-sponsored policy and procedures manuals, and staff training.

2. Ensures that each Family Care provider receives a copy of Policy 10.9.1.

3. Ensures that all staffs are aware of and implement Policy 10.9.1.

Each Sponsoring Agency annually recognizes the dedicated services of its Family Care providers by hosting an annual recognition event in honor of its Family Care providers. In order to encourage the continuation of these activities, funds are available in the Family Care Allocation to pay for the Family Care provider, and a guest, at a recognition event. Such events may be a brunch, a luncheon, a dinner, a picnic, or similar gathering, and may include such amenities as a plant, flowers, corsage, certificate of recognition, a plaque, or other appropriate awards. A sponsoring agency, if funds are available, is also encouraged to include respite sitters in its recognition activities.

A Sponsoring Agency may conduct a single or multiple events based on geographic needs. The cost of hosting this event(s) is determined by the Sponsoring Agency and is included in the Family Care Spending Plan. The *Standard Voucher, AC 92*, must include the Family Care Cost Center assigned to each DDSO, as well as, the appropriate object code.

For Agency Sponsored Family Care (ASFC), the cost of hosting this recognition event is included in the Residential Habilitation price. The ASFC recognition event may be combined with the DDSO event, with the ASFC agency paying for their cost of the event or the ASFC may choose to hosts its own recognition event.

SECTION 10.10

FISCAL SERVICES

10.10.1 Individual Needs, Entitlements, Determination, Expenditures, Implementation, Transfer of Clothing, Incidentals and Other Cultural Activities

10.10.2 Family Care Funding

10.10.3 Obtaining Funding for Individuals Eligible for Supplemental Security Income (SSI)

10.10.4 Funding Available from OMRDD

10.10.5 Refunding OMRDD When Supplemental Security Income (SSI) or Other Assets Become Available

10.10.6 Application for Medicaid for Individuals Without Adequate SSI or Adequate Funds to Pay for Medical Expenses

10.10.7 Reporting Changes in Personal and/or Financial Status to Social Security Administration Representative Payee, Director Sponsoring Agency

10.10.8 Reporting Changes in the Individual's Personal and\or Financial Status to Social Security Administration (SSA) by the Representative Payee Other than the Director Sponsoring Agency

10.10.9 Reporting of Changes in Personal and\or Financial Status to Social Security Administration (SSA) When the Individual is His or Her Own Payee

10.10.10 Payment to Family Care Provider for Individuals Who are in the Home A Portion of the Month

10.10.11 Voucher Reporting Requirements for Non-SSI Individuals

10.10.12 OMRDD Family Care Vouchering Process

10.10.13 Electronic Benefit Transfer (EBT) of Food Stamps Benefit

FAMILY CARE
INDIVIDUAL NEEDS ENTITLEMENT DETERMINATION
EXPENDITURE IMPLEMENTATION TRANSFER
OF CLOTHING INCIDENTALS AND
CULTURAL ACTIVITIES

April 2001 **Policy 10.10.1**

In accordance with the Mental Hygiene Law, Section 16.23 (e) funds may be available to individuals residing in Family Care homes for the replacement of clothing, personal requirements, and incidental needs, and for recreational, and cultural activities. These funds may be accessed if an individual meets current eligibility criteria as determined by their Medicaid eligibility or by the *OMR/FC-2, Personal Needs Eligibility Worksheet.* The Family Care Home Liaison (FCHL) working in consultation with the individual, the Family Care provider, and the sponsoring agency's business office determines eligibility. It is the responsibility of the Family Care Coordinator or designee to determine that the Family Care provider and the Home Liaison are aware of any additional funds available to the individual at the sponsoring agency prior to making a determination of need.

Pursuant to Chapter 809 of the Laws of 1980, a semiannual payment equal to 50% of the annual allowance must be made to Family Care providers for each individual for the following needs.

1. Clothing.

2. Personal and incidental needs.

3. Recreational and cultural activities.

The Family Care provider has the responsibility to maintain a separate expenditure log for each individual in his or her home for each payment period. This log must be available for inspection by authorized sponsoring agency staff at any time. The Family Care Home Liaison prior to determining the individual's need for a payment must review it. A receipt for any single expenditure of *$50* or more is to be attached to the appropriate log sheets. However in those situations in which the provider purchased clothing under $50, it is recommended that receipts be maintained in the event the article must be returned.

An automated payment process will make a semiannual payment on behalf of individuals who are Medicaid eligible, and who have been permanently placed in state or agency sponsored Family Care. The Personal Needs Eligibility Worksheet *will not be* required for these individuals; however, the Family Care Home Liaison will be responsible for determining the need to receive these funds *four weeks prior* to issuance of payment.

The Central Office Family Care Unit will notify DDSO Family Care staff of the scheduled payment run date as soon as the date has been confirmed with OMRDDs budget office.

It is the responsibility of the Family Care Coordinator or designee to ensure that *all* movement information in the Tracking and Billing System (TABS) is current and that each provider, state and ASFC, has a valid address in TABS.

The automated payment process may also be used for those individuals who are not Medicaid eligible, using the procedures found on page 3. For individuals moving into either State-Sponsored Family Care or Agency-Sponsored Family Care (ASFC), after the automated payment run, the *Personal Needs Eligibility Worksheet*, must be completed.

PROCEDURES FOR MEDICAID ELIGIBLE INDIVIDUALS LIVING IN STATE SPONSORED FAMILY CARE

RESPONSIBILITY		PROCEDURE
Family Care Coordinator	1.	Provides a listing of all Medicaid eligible individuals to the Home Liaison.
Family Care Home Liaison	2.	At least four (4) weeks prior to the processing of a payment, determines the need for this payment, consulting with the individual, the Family Care provider, the Business Office, and the local Revenue Support Agent.
	3.	Provides a list of all individuals that do not require payment by name and TABS ID# to the Family Care Coordinator or designee.
Family Care Coordinator (ASFC)	4.	Provides this list to the DDSO Family Care Coordinator or designated staff.
Family Care Coordinator/Designee	5.	Notifies Central Office of those individuals who must not receive payment or whose payment should be less than $250.

	6.	Notifies all Family Care providers of the payment run date.
Family Care Provider	7.	Maintains a record of all expenditures for clothing, personal needs, and/or recreational activities on *Form OMR/FC-a, Expenditure Log*. Attaches receipt for any single item of expenditure of $50 or more. However, it is recommended that receipts be maintained for items purchased under $50 in the event the item must be returned.
Family Care Home Liaison	8.	Reviews, at least quarterly, *Form OMR/FC-a* to determine that expenditures are in compliance with the Individuals Service Plan and Personal Expenditure Plan (PEP). Confirms review by signing name, and date on the next blank line of the *Expenditure*.
Family Care Coordinator/Designee	9.	Makes available a copy of the "Family Care Clothing Allowance Payment Report" and the "Family Care Clothing Allowance Exception Report" to the Family Care Home Liaisons.
	10.	Notifies Central Office Family Care Unit of any lost or missing clothing checks (ref. Policy 10.8.1 for procedures.
	11.	Mails to Central Office Family Care Unit any clothing checks inappropriately issued.

PROCEDURES FOR INDIVIDUALS WHO ARE MEDICAID INELIGIBLE LIVING IN STATE SPONSORED FAMILY CARE

RESPONSIBILITY	PROCEDURE
Family Care Coordinator	1. Provides a listing of all Medicaid ineligible individuals to the home liaison.
Family Care Home Liaison	2. Completes, at least *four weeks* prior to the processing of a payment F*orm OMR/FC-2, Personal Needs Eligibility Worksheet,* consulting with the individual, the Family Care provider, the business office, and the local Revenue Support Agent.
	3. Prepares, for ineligible individuals, Form *OMR/FC-1, Family Care Payment.*
	a. Completes Part I, Identification Data.
	b. Completes Part III-B or IV-B (as appropriate) to payment period equal to the amount in Part III of the *Personal Needs Eligibility Worksheet.*
	c. Completes Part III-B or IV-B, as appropriate to payment period, certifying expenditure for second half of prior year. Omit if initial request.

	4.	Submits with *OMR/FC-1, Family Care Payment Authorization, the OMR/FC-2 Eligibility Worksheet, and Form OMR/FC-a, Expenditure Log,* to the Family Care Coordinator for final approval, retaining copies of each form in the individual's record.
Family Care Coordinator	5.	Reviews the *Personal Needs Eligibility Worksheet, the Family Care Payment Authorization, and Expenditure Log,* and approves by signing the *Family Care Payment Authorization* on the designated line in the *Part III-B or IV-B,* as appropriate. Returns form (s) to the Family Care Home Liaison.
Family Care Home Liaison	6.	Retains the *Eligibility Worksheet*, and the *Expenditure Log,* in the individual's record.
	7.	Completes information at the top of *Form OMR/FC-a Expenditure Log.*
	8.	Gives the Family Care provider completed *Form OMR/FC-a, Expenditure Log.*
Family Care Coordinator (ASFC)	9.	Provides a list of individuals that should be added to the roster by name, TABS ID# and payment amount.
Family Care Coordinator/Designee	10.	Notifies Central Office of those individuals who must be added to the payment roster by name, by TABS ID#, and by payment amount.

11. Makes available a copy of the "Family Care Clothing Allowance Payment Report" and the "Family Care Clothing Allowance Exception Report" to the Family Care Home Liaisons.

12. Notifies Central Office Family Care Unit of any lost or missing clothing checks (ref. Family Care Policy 10.8.1 for procedures).

13. Mails to Central Office Family Care Unit any clothing checks inappropriately issued.

Family Care Provider

14. Maintains a record of all expenditures for clothing, personal needs, and/or recreational activities on *Form OMR/FC-a, Expenditure Log.* Attaches receipt for any single item of expenditure of *$50* or more. It is, however, recommended that receipts be maintained for items purchased under $50 in the event the item must be returned.

Family Care Home Liaison

15. Reviews, at least quarterly, *Form OMR/FC-a,* to determine that expenditures are in compliance with the Individualized Service Plan (ISP) and Personal Expenditure Plan (PEP). Confirms review by signing name, and date on the next blank line of the log.

TRANSFER PROCEDURE

If during the fiscal year the individual is transferred to another Family Care home or returns to the DDSO, the Family Care Home Liaison must immediately initiate completion of Part III of Form OMR/FC-1 certifying the appropriateness of expenditures to date, receipt of any unspent funds, and transfer of those funds to the new provider or business office, as follows:

Family Care Home Liaison

1. Completes name, and address of new provider(at the top of the form).
2. Fills in date transferred, amount paid to original provider during the semiannual period, amount spent by original provider, and balance unspent.
3. Obtains and signs expenditure log(s) from the original provider, and places them in the individual's file.
4. Obtains provider, and individual's signatures, and co-signs certification.
5. Obtains check or money order for balance from original provider.
6. Returns check to business office, or sends it to the new provider, with original copy of *Form OMR/FC-1 b,* and retains a copy.

Business Office

7. Deposits provider check in Advance Account or processes refund for appropriation.
8. If the individual moves to another Family Care home, issues check to new provider for the unspent balance of the payment.
9. Files Form OMR/FC-1.

State of New York
Office of Mental Retardation and
Developmental Disabilities

FAMILY CARE PAYMENT AUTHORIZATION
(For Clothing, Personal and Recreation Needs)

PART I IDENTIFICATION

Individual:

TABS ID No.

Provider Name:

Provider Address:

DDSO:

PART II

Use this box ONLY if the individual is transferred during the fiscal year

New Provider Name:

New Provider Address:

Complete Part V Below

PART III-A First Payment Authorization
April 1 through September 30

I hereby certify that the above named individual is eligible to receive the following payment: $_____

DATE FAMILY CARE HOME LIAISON

DATE FAMILY CARE COORDINATOR

Business Use Only *DATE:* _____

CHECK NO. SIGNATURE

PART IV-A Second Payment Authorization
October 1 through March 31

I hereby certify that the above named individual is eligible to receive the following payment: $_____

DATE FAMILY CARE HOME LIAISON

DATE FAMILY CARE COORDINATOR

For Business Use Only: *DATE:* _____

CHECK NO. SIGNATURE

PART III-B Certification of Expenditures
April 1 through September 30

I certify that the funds requested above were used for clothing, personal and/or recreational needs of this individual and that all required documentation has been supplied.

DATE INDIVIDUAL

DATE FAMILY CARE PROVIDER

DATE FAMILY CARE COORDINATOR

PART IV-B Certification Of Expenditures
October 1 through March 31

I certify that the funds requested above were used for clothing, personal and/or recreational needs of this individual and that all required documentation has been supplied.

DATE INDIVIDUAL

DATE FAMILY CARE PROVIDER

DATE FAMILY CARE COORDINATOR

PART V Transfer

Date of Transfer:

I certify that $ _____ was spent for clothing, personal and/or recreational needs of this individual to date.

Total Amount Received by Original Provider: $

Total Amount Spent to Date $

BALANCE: $

Amount Received from Original Provider: $

DATE INDIVIDUAL

DATE FAMILY CARE PROVIDER

DATE FAMILY CARE HOME LIAISON

DATE FAMILY CARE COORDINATOR/DESIGNEE

OMR/FC-2

PERSONAL NEEDS ELIGIBILITY WORKSHEET

Individual's Name _____ Medicaid Number _____

Provider's Name _____ Sponsoring Agency_____

PART I - SUPPLEMENTAL SECURITY INCOME AND/OR MEDICAID STATUS

1. a) Is the individual currently receiving SSI? Yes ( ) No ( )
   b) If Yes, skip to Part III and enter $250.
   c) If no, complete item 2 of this part.

2. a) Is the individual currently enrolled in Medicaid? Yes ( ) No ( )
   b) If Yes, skip to Part III and enter $250.
   c) If no, complete Part II.

PART II - ASSET/INCOME EVALUATION

1. a) Evaluation is based on assets and/or income for _____ (month and year).

2. a) Total assets from all sources. $ _____

   b) Current Medicaid asset limit. $ _____

   c) Excess assets (2a minus 2b; enter zero if negative). $ _____

   d) If line 2c is $250 or more, skip to Part III and enter zero.

   e) If line 2c is less than 250, complete items 3, 4, 5 & 6 below.

3. a) Total gross unearned income. $ _____

   b) Income disregard. $ 20.00

c) Net unearned income (3a minus 3b). $ _____

4. a) Total *gross* wages. $ _____

b) Income disregard if not used in item 3 above. $ _____

c) Work related exemption. $ 65.00

d) Sub-balance (4a minus 4b and 4c). $ _____

e) One-half sub-balance (net wages). $ _____

5. a) Total net income (3c plus 4e). $ _____

b) OMRDD allowance. $ _____

c) Adjusted net income (5a minus 5b). $ _____

d) Current provider payment $ _____

e) Excess income (5c minus 5d; enter zero if negative). $ _____

f) Health insurance premiums paid by the person. $ _____

g) Adjusted excess income (5e minus 5f). $ _____

h) Semiannual adjusted excess income (six times the amount on line 5g). $ _____

6. a) Full semi-annual payment. $ 250.00

b) Total excess assets and income (2c plus 5h). $ _____

c) Payment due (6a minus 6b; enter zero if negative). $ _____

d) If line 6c is zero, enter zero in Part III also.

e) If line 6c is greater than zero enter the amount in Part III.

Part III - PAYMENT AMOUNT

Enter this amount in section III A or IV of Form OMR/FC-1.

Prepared by:

Print Name	Print Title	Date
Signature	Title	Date

Eligibility Criteria for Payment Under Section 16.23(e) of the Mental Hygiene Law

I. Any Family Care individual authorized for SSI and/or Medicaid is eligible for payment under the Mental Hygiene Law.

II. Any non-SSI or non-Medicaid Family Care individual shall be eligible for Section 16.23(e) funding if the amount of available monthly income as determined by the guidelines in V. below is equal to less than the currently approved provider payment, and the amount of available assets does not exceed the current asset limit for Medicaid.

III. For any non-SSI, non-Medicaid individual with available assets in excess of the current Medicaid asset limit, the amount of excess will be used as a dollar-for-dollar offset to the semi annual payment under Section 16.23(e) of the Mental Hygiene Law.

IV. For any non-SSI, non-Medicaid individual with available income in excess of the currently approved provider payments:

1. The excess shall be reduced by the amount of any health insurance premiums paid directly by the individual.

2. The adjusted excess shall be used as a dollar-for-dollar offset to the monthly equivalent payable under Section 16.23(e) of the Mental Hygiene Law.

V. The amount of income available for contribution to the monthly provider payment shall be determined by subtracting the following deductions, exemptions and allowances from gross monthly unearned, or earned income, or both. In no case shall the amount of the individual's contribution exceed the current provider payment amount established by OMRDD.

1. Unearned Income Only

   a. A $20 income disregard.

   b. An individual's allowance as stipulated by OMRDD.

2. Earned Income Only

   a. The first $20 as an income disregard.

b. The next $65 as a work related exemption.

c. One-half the remainder after steps a. and b. are applied. This is also a work related exemption.

d. An individual allowance as stipulated by OMRDD.

3. Earned and Unearned Income

a. $20 of the unearned income as an income disregard.

b. The first $65 of earned income as work related exemption.

c. One-half of the earnings remaining after step b. is applied.

d. An allowance as stipulated by OMRDD.

FORM OMR\FC-a **EXPENDITURE LOG**

Sponsoring Agency: _____ County: _____

Individual's Name: _____

Family Care Provider's Name _____

Address: _____ Zip Code _____

DATE	ITEM PURCHASED	AMOUNT

Rev. 12/00

I certify that the funds received were used for the individual named above.

Provider's Signature: _____ Date: _____

Family Care Home Liaison Signature: _____ Date: _____

Rev. May 2004	FAMILY CARE FUNDING	Policy 10.10.2

Funding for Family Care is to be provided in a manner that ensures that all possible sources are used in meeting the total service needs of each individual placed in this program. The Revenue Support Agent is responsible for determining the funding sources, and methods of funding prior to the individual moving into Family Care.

RESPONSIBILITY	PROCEDURE
Family Care Coordinator or Other DDSO Staff	1. Notifies Revenue Support Agent of pre placement, and/or pre-admission meeting at least two weeks prior to the meeting date. a. Notification is to include the expected date of movement and the name and address of the Family Care provider. Notification should occur at least thirty *(30)* days prior to the actual movement unless there are less than thirty *(30)* days between the meeting date, and the movement date. b. Completes "Revenue Support Placement Notification" form, and sends to Revenue Support Agent. c. Advises Revenue Support Agent if the movement is for a trial visit.
Revenue Support Agent	2. Completes and send *Form BRO-321, Financial Summary Sheet,* when notified to attend planning meetings to discuss individual benefits. If unable to attend, sends the Family Care Coordinator the completed Form BRO-321 prior to the meeting. 3. Decides on the source or combination of sources to fund Family Care placement or admission which include: a Supplemental Security Income (SSI). b. Personal resources of those individuals who are legally responsible for the individual c. Office of Mental Retardation and Developmental Disabilities.

Revenue Support	4. Completes and distributes Form BRO-330 *Family Care Budget Sheet*, to notify the individual or outside fiduciary, the business office, Family Care provider, and where appropriate, other concerned parties of the details of the funding method, including specific amounts and sources of payment.
	5. Submits all applications related to the Family Care Funding.
	6. Makes all necessary arrangements with the Family Care Home Liaison, business office, outside fiduciaries, and any other parties required to take an active role in carrying out the payment plan.
Family Care Coordinator or Designee	7. Ensures that the Family Care funding is explained to the individual and that the individual obtains needed assistance in making payments if the individual receives income directly at the Family Care home.
Family Care Provider, Family Care Coordinator or Designee	8. Notifies Family Care Coordinator of any payment problems. If the individual's financial situation changes, the Family Care provider must contact the Family Care Coordinator.
Family Care Coordinator or Designee	9. Notifies the Revenue Support Agent of any problems that may arise with the Family Care provider receiving payments as stipulated in the payment plan.
Business Office or Outside Fiduciary	10. Submits payments to the Family Care provider in accordance with the arrangements made by Revenue Support Agent

FAMILY CARE
OBTAINING FUNDING FOR INDIVIDUALS ELIGIBLE FOR SUPPLEMENTAL SECURITY INCOME (SSI)

Rev. May 2004 **Policy 10.10.3**

As a result of changes in the Supplemental Security Income Program, the application date is no longer the effective date of benefits. The effective date of benefit payment is the first day of the month following the application date. When retroactive benefits are paid, it will no longer be possible to reimburse the Developmental Disability Service Offices for the partial month of the Family Care placement.

If an individual appears to be eligible for Supplemental Security Income (SSI), every effort is to be made to secure this source of revenue for the individual prior to moving to a Family Care home. The Family Care Coordinator, and the appropriate Revenue Support Agent are to work together toward this end.

RESPONSIBILITY	PROCEDURE
Revenue Support Agent	1. Reviews the individual's circumstances against the criteria of the SSI program, and determines whether or not to file an application.
	2. Prepares, if the individual appears to meet eligibility criteria, the application form and requests medical information, if needed, from the Family Care Coordinator. If the individual is to be his or her own payee, the agent will work with the Family Care Coordinator to obtain the individual's signature on the application form.
	a. Files, in all appropriate cases, the SSI application with the District Social Security Office which serves the sponsoring agency, and acts as liaison with the Social Security Administration (SSA) in all matters related to processing the application.
	b. Files a request for reconsideration with SSA if SSI is denied, and there appears to be sufficient reason to appeal that decision.
Family Care Coordinator/ Designee Medicaid Service Coordinator	3. Provides, upon request, the individual and the Revenue Support Agent with medical information to support the application.

Family Care Coordinator, Medicaid Service Coordinator, Office Clinical Staff, Family Care Provider, and/or Individual	4. Keeps the Revenue Support Agent advised of communication from the SSA relative to processing the SSI application and routes any additional information being sent to SSA through the Revenue Support Office.
	5. Provides the Revenue Support Agent with a copy of the SSI Award or Notice of Disapproval when it is received.
Revenue Support Agent	6. Completes and sends, if the individual is to receive temporary funding through OMRDD, Form BBRO-330, *Family Care Budget Sheet,* to the business office to provide notification of the amount of OMRDD voucher payment.
Business Office	7. Arranges for OMRDD vouchering if required by the payment plan as initial temporary measure while the SSI application is being processed.
Family Care Coordinator or Medicaid Service Coordinator or Family Care Home Liaison	8. Notifies the Revenue Support Agent of any problems related to receipt and use of the permanent Medicaid Card.
	9. Discusses proper use of the Medicaid card with the Family Care provider.
Social Security Administration	10. Determines the individual's eligibility for SSI, and issues the appropriate notice of approval or disapproval to: a. The individual, if capable. b. A representative payee.
	11. Selects the representative payee for the individual if indicated that the individual is incapable of handling funds. Payee preference of SSA is as follows: a. For an adult: 1). The legal guardian, spouse or other relative or friend who demonstrates a

strong interest in the personal welfare of the individual.

2). The DDSO Director.

b. For a minor child:

1). The natural or adoptive parent who is making the regular, and substantial contributions to the child's support or who shows an active continuing interest in the child's welfare.

2). A relative who makes regular, and substantial contributions to the child's support.

3). A legal guardian displaying an interest in the child's welfare.

4). The DDSO Director.

12. Issues, if an award is made, monthly payment checks, and also issues a separate check for payments retroactive to the first day of the month following the month of application or qualifying event, i.e., month of placement.

Business Office

13. Deposits, when the DDSO Director is the representative payee, SSI check against the individual's account, and issues a check to the Family Care provider for payment of current month's costs. Check is to be mailed from the business office as soon as possible, and not later than the *10th of the month for which it is issued.*

14. Notifies Revenue Support Agent, and Family Care Coordinator when first SSI check is received, and of any unexpected termination of receipt of checks.

Family Care Provider

15. Notifies the Family Care Coordinator or designee of any changes to or problems with the individual's

financial situation. If there is a shortfall in the payment of current month's costs, the individual must be given the full personal allowance and the Family Care provider must contact the Family Care Coordinator or designee to report the shortfall.

Form BRO 330 (MR) (2-96)

State of New York
Office of Mental Retardation
And Developmental Disabilities

FAMILY CARE BUDGET SHEET

Date: _____

Revenue Support Field Office

Individual: _____

_____

TABS ID#: _____

Telephone #: _____

DDSO: _____

Dear:

The monthly Family Care Budget for the above named individual has been determined as follows:

SOURCE OF FUNDING	Effective	Effective
Unearned Income		
SSI _____	____/____/____	____/____/____
_____	_____	_____
Earned Income	_____	_____
Other: _____	_____	_____
OMRDD Voucher TOTAL FUNDING		
PERSONAL ALLOWANCE	_____	_____
Unearned Income		
Earned Income	_____	_____
Other: _____	_____	_____
OMRDD Voucher	_____	_____
TOTAL PERSONAL ALLOWANCE		
PROVIDER PAYMENT	_____	_____
Unearned Income	_____	_____
Earned Income		
Other: _____	_____	_____
OMRDD Voucher TOTAL PROVIDER PAYMENT	_____	_____

If you have any questions about these financial arrangements, please contact the Revenue Support Office at the address or telephone number shown above.

Very truly yours,

White - Individual/Fiduciary Copy
Green - Agent Copy
Yellow - Home Liaison Copy
Pink - Family Care Provider Copy
Golden Rod - Business Office Copy

Revenue Support Agent

December 2000	FAMILY CARE FUNDING AVAILABLE FROM OMRDD	Policy 10.10.4

The Office of Mental Retardation and Developmental Disabilities will provide funding for individuals in DDSO-Sponsored Family Care homes who need temporary assistance while application for SSI benefits is pending; on an exceptional basis it will also provide funding for the support of individuals in DDSO Sponsored Family Care homes who are not eligible to receive SSI benefits. The Revenue Support Agent prior to moving the individual into Family Care determines the need for, and level of, such funding.

The Division of the Budget currently requires approval of voucher payments for all non- SSI individuals living in Family Care. Information, which identifies the payment level of all non-SSI eligible individuals living in Family Care homes, must be made available to the OMRDD Family Care Budget Analyst for Division of Budget review. This information is to be completed for each such individual on the Family Care Vouchered Person Information Sheet, and is to include the following data:

1. Age.

2. Disabilities, including IQ level.

3. Length of institutionalization.

4. Length of time the individual has lived in current Family Care home.

5. Reasons why Family Care was determined to be the most appropriate residential alternative at the time the individual initially began participating in the Family Care Program.

6. Rationale as to why Family Care continues to be the residence of choice.

7. The amount of the individual's monthly earnings, and the amount of the individual's contribution to Family Care costs.

This documentation must be provided whenever an individual moves into Family Care, and receives a notice of denial or discontinuation for SSI benefits, or when the amount of the Family Care voucher changes.

RESPONSIBILITY	PROCEDURE
Revenue Support Agent	1. Determines individual need for OMRDD funding because of circumstances such as: a. The individual needs temporary assistance while application for SSI benefits is pending. b. The individual is experiencing delays in obtaining personal funding. c. SSI has been denied because of lack of disability in conformance with SSI criteria, and the individual's income, and/or resources are not sufficient to pay Family Care costs.
	2. Determines amount, duration of voucher, and payment.
	3. Completes, and sends *Form BRO-330, Family Care Budget Sheet*, to Business Office, Family Care Provider, and Family Care Home Liaison to notify each of the amount, and duration of OMRDD voucher payment included in the overall payment.
Family Care Home Liaison	4. Discusses approved level of payment with the individual.
Business Office	5. Prepares the certified information in the voucher for payment to the Family Care provider at the approved level.

	6.	Submits a voucher in duplicate to the Department of Audit and Control before the *5th of each* month to ensure payment in a timely manner.
Business Office	7.	Submits one copy to the Revenue Support Agent to review against other sources of payment, and one copy to the Family Care Home Liaison.
Office State Comptroller	8.	Issues the check to the Family Care provider when it has performed its own audit, and is satisfied that all requirements are met. This check is issued as close to the first of the succeeding month as possible.
Family Care Home Liaison	9.	Notifies the Business Office, and Revenue Support when the first regular monthly SSI payment has been received in those instances where an individual is his or her own representative payee.
	10.	Advises the Business Office, and Revenue Support, if he or she, becomes aware that an outside representative payee has begun receiving the benefits on behalf of an individual.
Business Office	11.	Notifies Revenue Support and Family Care Home Liaison that regular monthly SSI payments are being received in those instances where the DDSO Director is the representative payee.
	12.	Discontinues submission of a voucher, as soon as, the first regular monthly SSI payment is received, and a revised *BRO-330* is received from Revenue Support.

Form BRO 330 (MR) (2-96)

State of New York
Office of Mental Retardation
And Developmental Disabilities

FAMILY CARE BUDGET SHEET

Date: _____

Revenue Support Field Office:

_____

_____

_____

Telephone #: _____

Individual: _____

TABS ID#: _____

DDSO: _____

Dear:
The monthly Family Care Budget for the above named individual has been determined as follows:

SOURCE OF FUNDING	Effective ___/___/___	Effective ___/___/___
Unearned Income		
SSI _____		
_____		
Earned Income		
Other: _____		
OMRDD Voucher		
TOTAL FUNDING		
PERSONAL ALLOWANCE		
Unearned Income		
Earned Income		
Other: _____		
OMRDD Voucher		
TOTAL PERSONAL ALLOWANCE		
PROVIDER PAYMENT		
Unearned Income		
Earned Income		
Other: _____		
OMRDD Voucher		
TOTAL PROVIDER PAYMENT		

If you have any questions about these financial arrangements, please contact the Revenue Support Office at the address or telephone number shown above.

White Copy - Individual/Fiduciary Copy
Green - Agent Copy
Yellow - Home Liaison Copy
Pink - Family Care Provider Copy
Golden Rod - Business Office Copy

Very truly yours,

Revenue Support Agent

December 2000	FAMILY CARE REFUNDING OMRDD WHEN RETROACTIVE SSI OR OTHER ASSETS BECOME AVAILABLE	Policy 10.10.5

When a retroactive SSI award is made to a Family Care individual funded by OMRDD on a temporary basis until SSI benefits begin, steps are to be taken to recover the amount of duplicate payments received by the individual.

RESPONSIBILITY	PROCEDURE
Business Office	1. Notifies the Revenue Support Agent immediately upon receipt of the first SSI check when the DDSO Director is representative payee.
Revenue Support Agent	2. Prepares, upon receiving notification that an individual has been awarded SSI benefits, *Form BRO-330, Family Care Budget Sheet.* The original is sent to the outside fiduciary or to the individual if he or she is managing his or her own funds, and copies are sent to the Medicaid Service Coordinator, the business office, and the Family Care provider.
	3. Determines, using *Form BRO-330*, and previous vouchers of Family Care funding, the total amount to be recovered.
	4. Sends *LRRO-05, Voucher Repayment Memo* to the business office stating the amount of money to be recovered from the individual's personal account. or an individual with an outside fiduciary sends a letter to that individual stating (claiming) the amount to be turned over to OMRDD.
Business Office, in Cooperation with Revenue Support Agent	5. Ensures recovery of funds from the individual, and/or Family Care provider.

Business Office

6. Forwards the recovered funds to the Division of Revenue Management's Cash Log-In Unit with *AC 1286* Forms within *30* days of recovery. Transmittal of refunds must indicate the individual's name, the Family Care provider's name, the amount recovered, and the period of time represented by the recovered funds.

7. Completes and sends, after forwarding recovered funds to Revenue Support, *Form LRRO-05* Business Office or a copy of *Form AC 1286* to the Revenue Support Agent to inform him or her that the funds have been forwarded to the Cash Log-In Unit.

8. Notifies Revenue Support Agent if it is unable to recover overpayment.

Revenue Support Agent

9. Attempts to recover overpayment, in either lump sum or by establishing a payment plan.

   a. Instructs, if successful, the individual or outside fiduciary to forward funds directly to the Business Office for deposit in the individual's personal account. (The Business Office processes funds as in #6 and #7 above).

   b. Refers, if unsuccessful, matter to Attorney General's Office for legal action, if appropriate.

FAMILY CARE
REFUNDING OMRDD WHEN RETROACTIVE SSI OR OTHER ASSETS BECOME AVAILABLE

When SSI benefits or other funds become available to an individual who was placed on the OMR voucher on a temporary basis, the Revenue Support Field Office (RSFO) notifies the Business Office:

1) Of the amount to be recovered from the individual's personal account, and

2) To remove the individual from the OMR voucher.

If the director is not the Representative Payee (RP) the Revenue Support Field Office notifies the outside payee of the amount to be recovered with instructions to forward the payment to the Business Office. A copy of the memo is sent to the Business Office. The Business Office uses the *Form AC 1286*, Refund of Appropriation Expenditure, to forward the recovery to the Cash Unit in Albany.

LLRO-5

FAMILY CARE VOUCHER PAYMENT MEMORANDUM DATE _____

TO: _____

FROM: _____ Revenue Support Agent

SUBJECT:

This individual was on the Family Care voucher and now has funds for voucher repayment. Please take action to repay the voucher from the individual's personal account as follows:

MONTH/YEAR	AMOUNT VOUCHERED	AMOUNT TO BE REPAID
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	TOTAL _____	TOTAL _____

Once this action has been accomplished, please complete and return the bottom portion of the memorandum or a copy of Form AC-1286 to the Revenue Support Agent.

Thank you.

TO: _____

FROM: _____ Revenue Support Field Agent

SUBJECT: _____

The Family Care voucher has been repaid as follows:

Date of Repayment: _____

Amount of Repayment: _____

Signature: _____

Title: _____

Date: _____

cc: Family Care Coordinator

Form BRO 330 (MR) (2-96)

State of New York
Office of Mental Retardation
and Developmental Disabilities

FAMILY CARE BUDGET SHEET

Date: _____

Revenue Support Field Office:

_____

_____

_____

Telephone: _____

Individual: _____

TABS ID # _____

DDSO _____

Dear:

The monthly Family Care Budget for the above named individual has been determined as follows:

	Effective	Effective
SOURCE OF FUNDING Unearned Income SSI _____ _____ Earned Income Other _____ **OMRDD Voucher** **TOTAL FUNDING**		
PERSONAL ALLOWANCE Unearned Income Earned Income Other _____ OMRDD **Voucher** **TOTAL PERSONAL ALLOWANCE**		
PROVIDER PAYMENT Unearned Income Earned Income **Other** _____ **OMRDD Voucher** **TOTAL PROVIDER PAYMENT**		

If you have any questions about these financial arrangements, please contact Revenue Support Office at the address or telephone number shown above.

White copy - Individual/Fiduciary
Green - Agent Copy
Yellow- Family Care Home Liaison Copy
Pink - Family Care Provider Copy
Golden Rod - Business Office Copy

FAMILY CARE REFUNDING OMRDD WHEN RETROACTIVE SSI OR OTHER ASSETS BECOME AVAILABLE

December 2000 | Policy 10.10.5

AC 1280 (2-96) STATE OF NEW YORK REFUND OF APPROPRIATION EXPENDITURE

			Voucher No.
Originating Agency		Orig. Agency Code	P. Contract
Payment Date (MM) / (DD) / (YY)	OSC Use Only	Liability Date (MM) / (DD) / (YY)	
Payee ID	Additional	Zip Code	Payee Amount Refunded
Payee Name (Limit 30 Spaces)		IRS Code (Formerly 1099)	
Payee Name (Limit 30 Spaces)		Statistic Type	Statistic
Address (Limit 30 Spaces)			
Address (Limit 30 Spaces)			
City	State	Zip Code	
Fund Name		Fund Code	Amount
Fund Name		Fund Code	Amount
Fund Name		Fund Code	Amount

Attached _____ in the amount of $ _____ is forwarded for deposit in the
(Insert check number or other identification)

appropriate checking account. Basis for this request is: _____

_____

_____ Agency Finance Officer _____ Date _____

OSC Review Reviewed by _____ Initial and Date	To Division of Treasury Approved by Office of State Comptroller for Deposit in the General Checking Account or Account Number _____ Bank Name _____ Signature _____ Date _____

Expenditure									Liquidation		
Cost Center Code					Accum.						
Dept	Cost Center Unit	Var.	Yr.	Object	Dept.	Statewide	Amount	Orig. Agency	Contract	Line	

OSC

☐ Check if Continuation Forms Attached

FAMILY CARE
APPLICATION FOR MEDICAID FOR INDIVIDUALS WITHOUT ADEQUATE FUNDS TO PAY FOR MEDICAL EXPENSES

December 2000 **Policy 10.10.6**

Individuals are to be assisted in applying for Medicaid benefits if they are not eligible for Supplemental Security Income (SSI), and have sufficient funds to pay for Family Care but lack additional resources to meet medical expenses. The local Revenue Support Field Office (RSFO) is responsible for processing such applications. Individuals authorized to receive SSI are automatically enrolled in Medicaid.

RESPONSIBILITY	PROCEDURE
Revenue Support Agent	1. Determines, in preparing the overall payment plan, that circumstances call for submission of an application for Medicaid separate from SSI.
	2. Requests the Family Care Home Liaison or appropriate DDSO staff, to prepare a *Disability Statement (Form DSS 639)* if needed.
Family Care Home Liaison or Other DDSO Staff	3. Submits upon receipt, a disability statement to Revenue Support Agent.
Revenue Support Agent	4. Determines individual's eligibility and sends Medicaid notices to outside fiduciaries.
	5. Issues a temporary Medicaid card, if appropriate, until the permanent card is available. The permanent Medicaid card will be issued through a subsystem of the Welfare Management System and will be sent directly to the individual's mailing address.

	6. Advises the Family Care Home Liaison or other DDSO staff of the denial of Medicaid Assistance by the New York State Department of Health.
Family Care Provider	7. Notifies appropriate DDSO staff of obligation to pay medical bills.
Family Care Home Liaison	8. Notifies the Family Care Home Liaison of the receipt of the Medicaid card.
	9. Notifies the Revenue Support Agent of any problems with the Medicaid card such as usage, damage to, lost of, etc.
	10. Discusses proper use of the Medicaid card with the Family Care provider, and monitors the situation to ensure that the card is being used in accordance with guidelines set forth by the New York State Department of Health.

Form DSS-639

DISABILITY REVIEW TEAM CERTIFICATE OF NEW YORK

DEPARTMENT OF HEALTH

1. CASE NUMBER	2. CASE NAME (LAST, FIRST, MIDDLE)	3. EXPIRATION DATE
4. I.D. # (CIN)	5. NAME OF AGENCY	
6. DATE OF THIS REVIEW	7. DIAGNOSIS	

8. REVIEW TEAM'S DETERMINATION (WRITTEN EXPLANATION MUST BE COMPLETED IN # 10).	9. EFFECTIVE DATE OF DISABILITY
☐ APPROVED ☐ GROUP I ☐ GROUP II ☐ DISAPPROVED ☐ NO ACTION DATA INADEQUATE ON ☐ MEDICAL ☐ SOCIAL	

10. REQUESTS FOR ADDITIONAL DATA OR REASONS FOR DETERMINATION

11. SIGNATURE OF REVIEWING PHYSICIAN	12. SIGNATURE OF REVIEWING SOCIAL WORKER

DSS-639 (Rev. 5/87) **INSTRUCTIONS**

Disability Review Team Certificate

1. **Agency Instructions**

   Items 1 (Case Number), 2 (Case Name), 4 (Client I.D.#) and 5 (Name of Agency) are to be completed by the appropriate local district worker.

2. **Review Team Instructions**

Item 3 (Expiration Date).	**Enter the expiration date if the case has been classified as Group II. The initial time interval shall be no less than one year from the effective date of the disability (indicated in Item 9). However, the Disability Review Team may request that additional data or a progress report be submitted at any time during such twelve-month period. Group I cases do not have to be submitted for further eligibility determination unless the factors of medical or social eligibility change.**
Item 6 (Date of Review).	**Enter the date the Review Team made the present determination.**
Item 7 (Diagnosis).	**Enter the primary and any other diagnosis being considered by the Disability Review Team.**
Item 8 (Review Team's Determination).	**Indicate whether a case is "Approved", "Disapproved", or "No Action", indicate whether the medical and/or social data is inadequate.**
Item 9 (Effective Date of Disability)	**Enter the effective date of medical disability established by the Review Team. (See Department Regulations 360.40 as reflected in the MA Disability Manual for instructions.)**
Item 10 (Request for Additional Data or Reasons for Determination	**This section must be completed in all cases to demonstrate the reason(s) for the determination. Regulatory citations such as, specific listing of impairment(s) evaluated, the client's residual functional capacity and applicable medical/vocational considerations or failure to meet durational requirement must be detailed in this section to indicate a rationale for the Review Team's decision. If any medical and/or social evidence is lacking in the record in order to make a determination, it should be indicated. Further, if specific documentation is needed for recertification for Group II cases, it should be noted.**
Item II (Signature of Reviewing Physician) and Item 12 (Signature of Reviewing Social Worker)	**The reviewing physician and reviewing social worker sign names in full.**

FAMILY CARE
REPORTING CHANGES IN PERSONAL AND/OR FINANCIAL STATUS TO SOCIAL SECURITY ADMINISTRATION REPRESENTATIVE PAYEE (DIRECTOR)

December 2000 **Policy 10.10.7**

When the director of the DDSO is the representative payee for individuals living in Family Care, it is his or her responsibility to report to the Social Security Administration (SSA) any changes in personal, and/or financial status which may alter either the Supplemental Security Income (SSI) eligibility of an individual, the amount of an individual's SSI payment or other entitlement. To avoid the assessment of financial penalties to the individual due to delays in reporting such changes, the director of the DDSO is to ensure that the following changes are reported, within ten *(10)* days, to the Revenue Support Field Office (RSFO) based on that office instructions:

1. An increase or reduction in an individual's income.

2. A change in an individual's employment status as a result of:

   a. New employment;

   b. Change in place of employment;

   c. Termination of employment.

3. A change in an individual's address or living arrangements.

4. An improvement in an individual's disability.

5. An increase or reduction in an individual's assets (such assets include any resources available for an individual's own use which are in cash or payable in cash on demand such as savings accounts, checking accounts, stocks, bonds, and mutual funds).

6. A change in school attendance of a minor.

7. A change in an individual's marital status as a result of:

   a. the death of a spouse;

b. a separation for more than six months;

c. A divorce;

d. An annulment;

e. Marriage.

8. A change in a spouse's eligibility for SSI benefits.

9. Death of an individual.

The Executive Director of a voluntary agency, within ten (10) days, is responsible for sending the notification to the SSA of these reported individual status changes. The information must also be provided to the RSFO due to possible impact on the Medicaid eligibility.

The Business Office maintains the individual's personal accounts, and sends as requested by the local RSFO. It is also the responsibility of the Business Office to report to the local RSFO significant changes in an individual's personal account as they occur, and in no case more than *five (5)* working days after such changes have occurred. In the event of the death of an individual, the Business Office, at the direction of the RSFO, is to return, and/or ensure the return to the SSA of any unnegotiated checks.

The Family Care Home Liaison is responsible for reporting to the RSFO any changes in personal and/or financial status, and any known change in the representative payee's name or address within *five (5)* working days of the occurrence.

The RSFO will review and utilize all information provided by the DDSO to determine how changes may affect an individual's benefits. The RSFO is responsible for notifying the SSA of such changes within *ten (10)* days after the close of the month in which these changes occurred. The RSFO will notify the Business Office, and the Family Care Coordinator whenever there is a change in an individual's SSI status.

FAMILY CARE
REPORTING CHANGES IN PERSONAL AND/OR FINANCIAL STATUS TO SOCIAL SECURITY ADMINISTRATION REPRESENTATIVE PAYEE (DIRECTOR)

December 2000 **Policy 10.10.7**

In the event of the death of an individual, the Family Care Home Liaison is to immediately notify the RSFO and Business Office; the RSFO will notify the SSA. If the director of a voluntary sponsoring agency serves as the SSA/SSI representative payee, he or she is responsible for notifying the Social Security Administration.

This policy, and the subsequent procedures ensure compliance with the provisions of *20 CFR (Consolidated Fiscal Report) Part 416, Subpart G* governing the reporting requirements, and time frames for individuals participating in the SSI program administered by the Social Security Administration.

RESPONSIBILITY	PROCEDURE
Family Care Home Liaison or Other DDSO Staff	1. Advises the RSFO by Internal memo within *five (5)* working days when a change occurs in any of the following: a. Name or address of the representative payee. b. Earned income from any sources known. c. Unearned income from any sources known. d. Employment Status. e. Address or living arrangement. f. Individual's disability,(i.e., improvement). g. New bank accounts. h. Existing bank accounts. i. Other assets. j. School attendance of a minor.

k. Marital Status.
l. Spouse's eligibility for SSI benefits.

Revenue Support Field Office

2. Upon receipt of TABS, and/or the Individual's Cash reports indicating income and/or resource changes or the internal memo from the Home Liaison:

   a. Reviews, and, if necessary, verifies the information.

   b. Determines, according to SSI eligibility requirements, how changes may affect an individual's benefits.

   c. Completes *Form BRO 572, Notice of New SSI Status.*

   d. Sends above notice to the SSA within ten (10) days from the end of the month in which the change occurs.

3. Notifies the Family Care Home Liaison or Business Office of any changes in an individual's benefits (i.e., SSI payment).

Family Care Home Liaison

4. Immediately notifies the RSFO of the death or Other DDSO Staff of an individual by sending a memo to the agent.

Revenue Support Field Office

5. Notifies the SSA of the death of an individual within *ten (10)* days from the end of the month in which the individual's death occurred.

Business Office

6. Returns any unnegotiated checks to the SSA when an individual dies, or

7. If the individual's checks were being deposited directly into an account in a financial institution, immediately notifies such institution of the individual's death.

FAMILY CARE
REPORTING CHANGES IN INDIVIDUAL'S PERSONAL AND/OR FINANCIAL STATUS TO SOCIAL SECURITY ADMINISTRATION (SSA) BY REPRESENTATIVE PAYEE OTHER THAN DIRECTOR DDSO

December 2000 **Policy 10.10.8**

The representative payee, when other than the director of DDSO, has the legal responsibility to report to the Social Security Administration (SSA) any changes in an individual's personal, and/or financial status which may alter either the Supplemental Security Income (SSI) eligibility of an individual or the amount of an individual's SSI payment. To avoid financial penalties to the individual, the following changes must be reported to the SSA in accordance with their instructions, within *ten (10)* days after the close of the month in which these changes occurred:

1. An increase or reduction in an individual's earned or unearned income.

2. A change in an individual's employment status as a result of:

   a. new employment;

   b. change in place of employment;

   c. termination of employment.

3. A change in an individual's address or living arrangements.

4. An improvement in an individual's disability.

5. An increase or reduction in an individual's assets (such assets include any resources available for an individual's own use which are in cash or payable in cash on demand such as savings accounts, checking accounts, stocks, bonds, and mutual funds).

6. A change in school attendance of a minor.

7. A change in an individual's marital status as a result of:

   a. the death of a spouse;

   b. a separation for over *six months;*

   c. a divorce;

d. an annulment.

e. A marriage.

8. A change in a spouse's eligibility for SSI benefits.

9. Death of an individual.

When an individual's personal, and/or financial status information is available at the DDSO, Family Care Home Liaison is to provide such information to the representative payee, upon request, for the purpose of reporting to the SSA.

The Family Care Home Liaison is responsible for reporting to the Revenue Support Field Agent any changes in personal, and/or financial status and any known change in the representative payee's name or address. He or she is to report such known changes as they occur, and in no case more than *five (5)* working days after such changes are known to have occurred. This is for Medicaid purposes.

The Business Office is responsible for reporting any significant changes in an individual's account when such account is maintained at that office. In addition, any known changes in an individual's bank account when the individual's passbook is held at the Business Office are to be reported. Such changes must be reported to the RSFO as they occur, and in no case more than *five (5)* working days after such changes have occurred.

The RSFO will use all information provided by the DDSO to determine possible changes in an individual's benefits. The RSFO will notify the Home Liaison/Service Coordinator, and the Business Office whenever there is a change in an individual's SSI status.
In the event of the death of an individual, the Family Care Home Liaison is to immediately notify the RSFO.

This policy, and the subsequent procedures ensure compliance with the provisions of *20 CFR (Consolidated Fiscal Report), Part 416, Subpart G* governing the reporting requirements and time frames for individuals participating in the SSI program administered by the Social Security Administration.

FAMILY CARE
REPORTING CHANGES IN INDIVIDUAL'S PERSONALAND/OR FINANCIAL STATUS TO SOCIAL SECURITY ADMINISTRATION BY REPRESENTATIVE PAYEE OTHER THAN DIRECTOR

December 2000 **Policy 10.10.8**

RESPONSIBILITY	PROCEDURE
Family Care Home Liaison or Other DDSO Staff	1. Upon request, provides the representative payee with information on an individual's personal and/or financial status when such information is available at the DDSO. 2. Sends a memo to the RSFO within *five (5)* working days when a significant change occurs in any of the following: a. Name or address of the representative payee. b. Earned income from any sources known. c. Unearned income from any sources known. d. Employment status. e. Address or living arrangement. f. Individual's disability (i.e., improvement); g. New bank accounts. h) Existing bank accounts. I) Other assets. j) School attendance of a minor.

k) Marital status; or Spouse's eligibility for SSI benefits.

Revenue Support Field Office

3. Upon receipt of memo:

a. Reviews, and, if necessary, verifies the information.

b. Determines, according to SSI eligibility requirements, how changes may affect an individual's benefits.

c. Notifies the Family Care Home Liaison and Business Office of changes in an individual's benefit status such as receipt of or loss of SSI status.

Family Care Home Liaison or Other DDSO Staff

4. Immediately notifies the RSFO of the death of and individual by sending a memo to the RSFO.

FAMILY CARE
REPORTING OF CHANGES IN PERSONAL AND/OR FINANCIAL STATUS TO THE SOCIALSECURITY ADMINISTRATION (SSA) WHEN THE INDIVIDUAL IS THEIR OWN PAYEE

December 2000 **Policy 10.10.9**

When an individual is his or her own payee, it is the individual's legal responsibility to report to the Social Security Administration (SSA) any changes in personal, and/or financial status which may alter either the Supplemental Security Income (SSI) eligibility or the amount of SSI payment. To avoid financial penalties to the individual, the following changes must be reported to the SSA within *ten (10)* days after the close of the month in which these changes occurred:

1. An increase or reduction in earned or unearned income.

2. A change in employment status as a result of:

   a. new employment;

   b. change in place of employment;

   c. termination of employment.

3. A change in address or living arrangements.

4. An improvement in the individual's disability.

5. An increase or reduction in assets (such assets include any resources available for the individual's own use which are in cash or payable in cash on demand such as savings accounts, checking accounts, stocks, bonds, and mutual funds).

6. A change in school attendance of a minor.

7. A change in marital status as a result of:

   a. the death of a spouse;

   b. a separation for more than six months;

c. a divorce

d. an annulment.

e. a marriage.

8. A change in a spouse's eligibility for SSI status.

Although the individual (as payee) has the responsibility to report status change information to the SSA, it is the responsibility of the **Family Care Home Liaison**, whenever he or she is aware of a change, to ensure that the individual reports the change to the SSA within the required time frame.

There are three ways to report changes in personal and/or financial status to the SSA:

1. Telephones the district office of the SSA; or

2. Visits the district office of the SSA; or

3. Writes a letter to Social Security Administration, and sends the letter to the SSA.

The Family Care Home Liaison, when necessary, assists the individual in completing and submitting the letter to the SSA.

In addition, the **Family Care Home Liaison** is responsible for reporting to the Revenue Support Field Office (RSFO) any known changes in the individual's personal, and/or financial status, and any known change in the payee's name or address. He or she reports such changes as they occur, and in no case more than *five (5)* working days after such changes are known to have occurred. This reporting is necessary to ensure that the most up-to-date information on an individual's personal, and/or financial status is available to the RSFO. This is necessary because such changes may impact the individual's Medicaid eligibility.

Upon receipt of the *Data Change Reports*, the RSFO Agent will review, and, if necessary, verify all individual change information. In addition, the RSFO will use such information to determine possible changes in an individual's benefits. If requested, the RSFO will advise the individual and/or **Family Care Home Liaison** of how change(s) in the individual's personal, and/or financial status may affect the individual's SSI payment.

In the event of the death of an individual, the **Family Care Home Liaison** is to immediately notify the RSFO; and will follow-up to confirm the return to the SSA of any unnegotiated individual checks; the RSFO will notify the SSA of the individual's death within *ten (10)* days from the end of the month in which the individual's death occurred.

This policy, and the subsequent procedures ensure compliance with the provisions of *20 CFR (Consolidated Fiscal Report), Part 416, Subpart G* governing the reporting requirements, and time frames for individuals participating in the SSI program administered by the Social Security Administration.

RESPONSIBILITY	PROCEDURE
Family Care Home Liaison	1. Upon learning of a change in the individual's personal and/or financial status: a. Immediately advises the individual and the **Medicaid Service Coordinator,** to remind him or her to report the change to the SSA within *ten (10)* days from the end of the month in which the change occurred. b. When necessary, assists the individual in reporting the change to the SSA within the required time frame in one of the following ways:

i. telephoning the district office of the SSA; or

ii. visiting the district office of the SSA; or

iii. Writing a letter to SSA, and sending this form to the SSA.

2. Sends a memo to the local RSFO within *five (5)* working days when a significant change occurs in any of the following:

a. Name or address of the representative payee.

b. Earned income from any sources known.

c. Unearned income from any sources known.

d. Employment status.

e. Address or living arrangement.

f. Individual disability, i.e., improvement.

g. New bank accounts.

h. Existing bank accounts.

i. Other individual's assets.

j. School attendance of a minor.

k. Marital status; or

l. Spouse's eligibility for SSI benefits.

Revenue Support

3. Upon receipt of *Form OMR 271, Person Data* Field Office *Change Reports*:

a. Reviews and, if necessary, verifies the information;

b. Determines, according to SSI eligibility requirements, how changes may affect an individual's benefits.

c. If requested, advises the individual and the **Family Care Home Liaison** of how changes may affect an individual's benefits (i.e., SSI payment).

Family Care Home Liaison

4. Immediately notifies the **Medicaid Service Coordinator,** Revenue Support or Other DDSO Staff Field Office of the death of an individual by sending a memo.

Revenue Support
Field Office

5. Notifies the SSA of the death of an individual by sending a letter to the SSA within *ten (10)* days from the end of the month in which the individual's death occurred.

Family Care Home Liaison

6. Returns any unnegotiated individual checks or other DDSO Staff to the SSA when an individual dies, or

7. If the individual's checks were being deposited directly into an account in a financial institution, immediately notifies such institution of the individual's death.

FAMILY CARE
FORM BRO 572
NOTICE OF NEW SSI STATUS

FAMILY CARE
PAYMENT TO PROVIDER
FOR INDIVIDUALS WHO ARE IN THE HOME
Rev. December 2000 FOR A PORTION OF A MONTH Policy 10.10.10

A Family Care provider will be reimbursed on a per diem basis for the room and board care provided to an individual residing within his or her home regardless of the length of the individual's stay within the home. However, the Family Care provider is not paid for the day the individual leaves the home. The per diem rate is equal to the monthly Supplemental Security Income room and board payment divided by *30 days.*

The Family Care provider of the home the individual is leaving must return to the Family Care Home Liaison the remaining portion of the monthly Family Care stipend as determined by the Revenue Support Field Office (RSFO) or the sponsoring agency business office. Any unspent portion of funds for clothing, personal allowance or food stamps (ref. Policy 10.10.13 *Usage of Individual's Food Stamp Benefit*) must be available to the individual in the new Family Care home.

If the individual dies before the sponsoring agency business office issued the room and board check, the check may be prorated for the actual number of days spent in the Family Care home. If a death occurs while the individual is residing in Family Care, the provider may retain the unspent portion of the room and board funds that have been paid on behalf of that individual. The sponsoring agency may require documentation of costs incurred by the provider for the individual's care for that month. The provider must, however, return any unspent portion of the personal allowance funds to the sponsoring agency, unless the provider can validate, with receipts or notations in the ledger, those expenditures.

The sponsoring agency must also insure that all personal property (for example-television, clothing) of the deceased individual is collected and placed in a secure location until appropriate disposition can be determined. A notification process must be in place to inform relatives of their ability to claim these items. Items purchased under the group purchase policy are excluded from this process.

RESPONSIBILITY	PROCEDURE
Family Care Home Liaison	1. Notifies Revenue Support Field Office of change in the individual's address.
Revenue Support Field Office	2. Notifies all necessary parties of change in the individual's address.
	3. Determines, in consultation with the Family Care Home Liaison, an appropriate amount of payment to the Family Care provider based upon the length of the individual's residence in the home.
	4. Notifies the Family Care Home Liaison in writing of the amount of excess payment to the Family Care provider to be returned.
Family Care Home Liaison	5. Notifies the Family Care provider in writing of the amount of excess payment to be returned.
Family Care Provider	6. Returns excess payment, to the DDSO Business Office. This may be done through the Family Care Home Liaison.
Business Office	7. Mails receipt to provider for money returned.

FAMILY CARE
VOUCHER REPORTING REQUIREMENTS
FOR NON-SSI INDIVIDUALS

Rev. May 2004 **Policy 10.10.11**

The Division of the Budget (DOB) currently requires individual approval of voucher payments for all Non Supplemental Security Income (SSI) individuals in Family Care homes. Information which identifies the payment level for all non-SSI eligible individuals residing in Family Care homes must be made available to the OMRDD Family Care budget analyst for DOB review. This information is to be completed by Family Care staff or the Business Office for each such individual on the Family Care Vouchered Person Information Sheet. An agency, providing Agency Sponsored Family Care, must contact the local DDSO Family Care Coordinator or designee to request vouchering for persons who are non-SSI eligible.

The Family Care Vouchered Sheet should include the following information:

1. Age.
2. Disabilities, including IQ level.
3. Length of individual's institutionalization, if any.
4. Length of placement in current Family Care Home.
5. Total length of time spent in a Family Care Home.
6. Reasons why Family Care was determined to be the most appropriate residential alternative at the time of initial placement/admission into the program.
7. Rationale as to why Family Care is, or continues to be, the most appropriate residential alternative for the individual.
8. The amount of individual's monthly earnings and the amount of individual's contributions to Family Care costs.

This documentation must be provided whenever an individual placed into a Family Care home receives a notice of denial or discontinuation for SSI benefits, or when the amount of the Family Care voucher changes.

RESPONSIBILITY	PROCEDURE
Revenue Support Field Office	1. Receives notice of denial, discontinuation, or change in the amount of SSI benefits.
	2. Notifies the Family Care Home Liaison of the notice of denial or discontinuation for SSI benefits, and the amount of the voucher. Also completes, and sends *Form BRO-330, Family Care Budget Sheet*, to the Business Office.
Family Care Coordinator or Designee	3. Ensures completion of the Family Care Vouchered Information Sheet, and sends it to OMRDD Family Care Budget Analyst.

When a Revenue Support Field Office (RSFO) is notified of an individual's proposed or actual admission to a Family Care home, the RSFO determines the method of funding for the cost of the individual's care in the Family Care home. The following sources are considered in determining the need for and level of such funding:

1. The individual's personal income, and/or assets, or those of persons legally responsible for the individual.

2. Supplemental Security Income (SSI), which is a federally funded program of financial assistance to individuals who are disabled, includes money for room and board plus a monthly stipend for personal needs; or

3. The Office of Mental Retardation and Developmental Disabilities (OMRDD) Voucher.

The RSFO completes and distributes *Form BRO-330* (see attached), the *Family Care Budget Sheet,* to advise everyone - the individual, and/or outside fiduciary, the Family Care Home Liaison/ Medicaid Service Coordinator, the DDSO Business Office, and the Family Care provider - of the details of the funding plan.

If the RSFO determines that the individual needs temporary assistance, OMRDD will provide funding for the monthly payment on the OMRDD Voucher. OMRDD will provide funding for individuals in Family Care homes who need temporary assistance while their applications for Supplemental Security Income (SSI Status) are pending, while the Social Security Administration (SSA) processes a change in the individual's SSI benefit amount or the SSI benefit has been reduced to recover an overpayment. On an exceptional basis, the OMRDD will also provide funding for the support of individuals who are not eligible to receive SSI and whose income and/or assets are not sufficient to pay Family Care costs.

Various laws regulate the amount of the temporary funding:

1. Part 633 states that "for persons residing in Family Care homes the amount is determined by using the current amount stated in Section 131-o Social Services Law, plus any and all income exemptions provided for in current regulations governing SSI and Medicaid eligibility".

2. The Social Security Act states "that if an individual who is receiving SSI has any other income; he or she is entitled to an extra $20 each month". The Social Security Act also mandates that an individual is entitled to a personal needs allowance.

3. New York State Law (Social Services Law 131 - o) states "that anyone with the optional state supplementation included in his or her SSI benefit (as in Family Care), gets an extra $20 in his or her personal allowance each month".

Upon notification that an individual has been awarded SSI benefits or as other funds become available, the RSFO immediately advises the Business Office to move the individual's name from the OMRDD Voucher.

RSFO determines the amount to be recovered in order to repay the OMRDD Voucher. If the Business Office is responsible for the individual's personal account, the Business Office recoups the amount from the individual's personal account. If the individual has an outside fiduciary or another person managing his or her funds, the RSFO sends a letter to that person as notification of the amount of money to be reimbursed to OMRDD.

The recovered funds are transmitted to Revenue Support, Cash Unit, 44 Holland Avenue, Albany, New York 12229

PLEASE NOTE:

There have been occasions when the Office of the State Comptroller (OSC) has questioned OMRDD Voucher payments that exceed the minimum SSI benefit level. The Business Office can justify the payments by referring to various laws affecting the payment amount, and stressing the fact that most voucher payments are reimbursed when SSI benefits are awarded or other income become available.

March 2001	FAMILY CARE USAGE OF INDIVIDUAL'S FOOD STAMP BENEFIT	Policy 10.10.13

When an individual living in Family Care is the recipient of a food stamp benefit, the provider will receive an Authorized Representative Card with their name and the name of the recipient on it. The provider will receive separately a Personal Identification Number (PIN) to be used with the card.

A provider who has several food stamp recipients may wish to call the Customer Service number on the card or go to the local food stamp district office to change all the PINS to one unique number of their choosing. The card and PIN will be used like a debit card to purchase food at grocery stores.

The card MUST be kept in a secure place because it is like cash. The provider MUST never give anyone else the PIN.

Cash will not be received as change for any portion of the benefit that is unused. The remainder will be carried forward in the account to the next month and receipts will be given after each purchase to show the remaining balance. A provider may call Customer Service to obtain the balance if she or he does not have the receipt.

While the monthly benefit SHOULD be available no later then the 10th of the month, the United States Department of Agriculture Regulations state that "the provider is only allowed to access a pro-rated share of the current benefit on or before the 15th of the month". Effective the 16th of the month a provider is free to use any or all of the monthly benefit. This is due to the fact that if an individual leaves the Family Care home on or before the 15th of the month a portion of the benefit MUST be available to that individual in the new Family Care home.

The food stamp benefit MUST be accessed at least ONCE in a 60-day period. If not, a recertification will automatically be generated to determine if the benefit is warranted.

If the card is LOST or STOLEN the provider MUST first call the Customer Service number to freeze the account, then notify the Revenue Support Field Office so that a new card can be requested.

Once an individual leaves a Family Care home or dies, the provider MUST destroy the Authorized Representative Card.

SECTION 10.11

LOANS FOR HOUSING SUPPORT

10.11.1 Environmental Modifications (Assistive Technology)

10.11.2 Adaptive Devices (Assistive Technology)

10.11.3 Assisting with Leasing

10.11.4 Downpayment and\or Renovation

10.11.4A Application for Downpayment and\or Renovation.

Rev. April 2001	FAMILY CARE ENVIRONMENTAL MODIFICATIONS (ASSISTIVE TECHNOLOGY)	Policy 10.11.1

In August 1991, the Office of Mental Retardation and Developmental Disabilities (OMRDD) entered into the Home and Community Based Services (HCBS) waiver, and for the first time implemented an approach to service delivery that was not dependent upon a program model but was available to individuals where they lived. A second change to the provision of services was the extent to which informal community supports began to be incorporated into everyday life for individuals needing service.

Since the introduction of the Individualized Service Environment (ISE), OMRDD has continually strived to improve the availability and quality of services. One area of growing interest is Assistive Technologies (AT) that can be either environmental modifications (E-Mods) or Adaptive Devices (AD) that directly benefit the individual.

Environmental Modifications (E-Mods) are adaptations to the home that are necessary to increase or maintain a person's ability to live at home with independence. These adaptations address needs related to physical, behavioral, or sensory disabilities, and help ensure that a person's health, safety, and welfare needs are met. Environmental modifications must be part of the individual's service plan.

Environmental modifications are expected to be provided for the most part on a one-time-only basis per item per person. Exceptions must be approved by the DDSO. Approval for acquisition of items that were previously provided may be granted if movement to a new residence occurs because of circumstances related to the individual's health, welfare or safety, or other situations beyond the individual's control.

In the past the primary emphasis of this service has been on home adaptations that afford people with physical disabilities better access in the home. There are also technologies needed by people who have behavioral or sensory deficits to assure safety at home.

I. Allowable Environmental Modifications

Health Care Financing Administration (HCFA) has approved the following items in the HCBS waiver agreement:

A. Modifications to address a person's physical disabilities, allowing more safe and improved access and/or functioning within the home environment, including:

I. Ramps.

II. Lifts (hydraulic, manual, or electrical) for porch, stairs, and/or bathroom.

III. Widened doorways/hallways.

IV. Hand railings/grab bars.

V. Automatic or manual door openers/door bells that are required as part of a residential habilitation service plan.

VI. Bathroom/kitchen modifications or adjustments, such as:

a) Roll-in showers.
b) Sinks/tubs.
c) Water faucet controls.
d) Plumbing adaptations (cut-outs, toilet/sink adaptations).
e) Turnaround space changes/adaptations.
f) Worktables/work surfaces adaptations.
g) Cabinet/shelving adaptations.
h) Shatterproof bathroom/shower doors.

B. Modifications that address a person's sensory deficits, facilitating a more safe environment, including:

I. Braille identification systems.

II. Tactile orientation systems.

III. Bed shaker alarm devices.

IV. Strobe light smoke detection and alarm devices.

C. Modifications that promote a safer environment for people with challenging behaviors, including:

I. Window protection.

II. Reinforcement of walls.

III. Open-door signal devices.

IV. Durable wall finishes.

D. Other adaptations including:

I. Medically necessary heating/cooling adaptations as required as part of a residential habilitation services plan or medical treatment. (Any such adaptations used solely to improve a person's living environment are to be included as part of room and board costs and not considered E-Mods.)

II. Electrical wiring to accommodate other adaptations or equipment installation.

III. Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the person's welfare.

IV. Other appropriate environmental modifications, adaptations, or repairs necessary to make the living arrangement suitable for the person and which are not items of general utility.

The HCBS waiver will fund such items if:

1. They are not required by local codes.

2. The ISPs for the people who are or will be living in the Family Care home clearly support the need for such devices/construction. It is expected that these will be accomplished in as cost effective a manner as possible.

3. They are required by local codes, the waiver will not fund generic items such as fire alarm/smoke detector systems (ref Family Care Policy 10.2.2) or ground fault interrupters or anti-scald devices.

4. It can be clearly supported by the needs of a specific individual such as a bed alert for persons who are blind or a strobe light attached to the fire alarm system, if a person with a hearing impairment lives in the home, and his or her ISP indicates the need for such a device.

5. The portions of design fees that can be attributed to the environmental modifications, and the appropriate portion of payments made to cover contingency costs.

6. The construction/repairs to walkways are needed for the individual to get to the vehicle from the home.

7. It is documented in the ISP that the installation of fences are required for the safety and security of the individual. A fence may also be installed for a seeing eye dog if required for the maintenance and security of the animal. The extent and type of fencing is at the discretion of the DDSO.

8. Replacement of items that have worn out through normal everyday use (faucet controls, ramps, handrails, etc.) may be replaced by the same procedures that were followed in acquiring them originally. There may be situations in which replacement or repair would be contingent on establishing a plan that would minimize the chance of repeated loss or damage.

II. Environmental Modifications and the Individualized Service Plan (ISP)

Any Environmental Modifications being funded through the HCBS Waiver must be specifically listed in the Waiver Services section of the ISP. The Federal share for the cost of the items cannot be claimed if they are not in the ISP. For example, if someone uses a wheelchair for mobility, and ramps need to be installed at the Family Care home, the fact that the person needs a wheelchair to get around should be indicated in the profile section of the ISP.

The construction of ramps, widening of doors, etc. should be listed as Environmental Modifications under Waiver Services. If someone requires fire protection items that are not required by the local building code, the profile section should indicate what limitations the person has in terms of evacuating the residence in a timely way and the device (e.g., sprinkler system) listed as an Environmental Modification under Waiver Services.

The following is an example of how Environmental Modifications are documented under Waiver Services in an ISP. It is assumed here that the profile section of the ISP adequately supports the need for these items (e.g., Joe needs a wheelchair for mobility).

ISP - Section 2 HCBS Waiver Services

Environmental Modifications:

Grey County ARC will provide the following Environmental Modifications to help Joe access his home and increase his ability to live at home with independence: Ramps for the front and side doors, a widened doorway to the bathroom, wheelchair accessible bathroom fixtures, and bathroom handrails/grab bars.

Frequency: One time purchase
Effective Date and Duration: To be completed by 9/1/00

III. Alternatives to HCBS Funding

The person-centered approach to planning revolves around relationships between a person with developmental disabilities and his or her community. Reciprocal relationships enhance a person's life in the community, and it is through these relationships that support networks can be created to complement funded services. All resources should be considered as a person builds a life within the community.

Individuals, advocates, and service coordinators should consider the use of natural supports when acquiring environmental modifications. Fund-raising activities in the community frequently benefit particular individuals or families. Businesses, banks, civic organizations, church groups, and unions will often donate labor and building materials to assist someone who needs an item such as a ramp, handrail, or bathroom modification. A potential employer, for example, could provide materials for a ramp, and the labor for installation might be donated by a business or civic organization.

Annual Dollar Limit - OMRDD has established funding annual ceilings per individual for environmental modifications, which DDSOs can approve. Information about the current funding ceilings is available from the DDSOs. For individuals living in certified locations, or for families with more than one person with developmental disabilities, the OMRDD State share ceiling is aggregated per person/year for those requiring environmental modifications. Proposals that exceed the DDSO funding ceiling must be submitted to the Central Office Budget Office and the Office of Waiver Management for approval.

Expertise Available - Professional staff are available to the individual, advocate, and service coordinator to provide guidance in evaluating the needs for environmental modifications as well as guidance related to actual construction. Making use of professional expertise will assure that the work done is of good quality, and that the safety and accessibility needs of the individual are taken into account (ref. Waiver Manual, 2001).

IV. Steps to Approval of Environmental Modifications

A. As part of developing the PISP/ISP, the applicant, the advocate, and the Medicaid Service Coordinator determine what environmental modification is desired, and, when necessary, obtain assistance from appropriate experts, such as people familiar with construction of environmental modifications and architects, to determine the feasibility of the modification.

B. If it is determined that the HCBS waiver is the most appropriate source of funding, this environmental modification service becomes part of the HCBS services requested in the PISP/ISP.

C. As part of the DDSO review of the PISP/ISP, the DDSO representative determines if funding is available for this service. To assist in this review, the applicant, advocate, and service coordinator must supply supporting documentation to the DDSO, including the approximate cost and effective date of the needed services. This can be submitted prior to or after the applicant moves to Family Care.

If renovations/construction work will be needed in the home, information needs to be obtained about the ownership of residence in which the individual lives and, if rented, who the landlord is. The individual, the advocate, with the assistance of the service coordinator or DDSO representative as needed, must obtain the owner's approval for the renovations, including any lease or rental contract language that may be necessary, given the extent of the modifications to the home. OMRDD will not be responsible for paying any cost of restoring a site to its original configuration or condition.

E. The enrolled individual, with the advocate and service coordinator, proceeds with the steps of the **procurement process** outlined according to where the individual lives. (ref. The section on " In Own Home or in Family Care " in *The Key To The Home and Community Based Services Waiver: A Provider Guide).*

V. Environmental Modifications Procurement Process for: People Living in Family Care

After the individual, advocate, and service coordinator have completed the appropriate Steps to Approval outlined above, the following steps are necessary to obtain the environmental modifications and arrange for payment:

A. As is noted in Step D of the Steps to Approval, the service coordinator will assist the individual, advocate, or Family Care provider in contacting the DDSO Waiver or CSP coordinator at the DDSO. This staff person will determine what funds are available in the HCBS waiver resources allocation and explain the process for securing the funds, including obtaining landlord approval in rental situations.

Medicaid is always the payer of last resort. The Family Care provider, individual, or advocate is obligated to first bill alternative coverage for this type of service before billing Medicaid under the HCBS waiver.

Reimbursement funding may be requested through a DDSO or voluntary agency authorized to provide environmental modifications. The DDSO or voluntary agency must be contacted, before going to bid, to review the plans. Any work done in a Family Care home must conform to Family Care certification requirements. The service coordinator should be prepared to assist the individual, advocate, or Family Care provider throughout this process.

B. The Family Care provider, individual, or advocate will contact the vendors (craftsmen) of environmental modification services and document price quotes or bids as specified below. The individual or advocate will communicate with the craftsmen to coordinate aspects of the construction such as scope of work; date to begin and conclude work, and assurance that the completed work is satisfactory. The service coordinator should assist in this process, using building experts as needed.

C. The individual, advocate, or Family Care provider, with assistance from the Medicaid Service Coordinator as needed, solicits bids based on a comparable scope of work for environmental modifications, good for a minimum of 180 days, as follows:

1. Up to $5,000, selects a reliable vendor (taking steps necessary to ensure reasonable pricing, including documentation that at least three (3) telephone quotes have been obtained) and obtains a written quotation from the selected vendor which includes all terms and conditions of sale.

2. $5,001 and above, solicits a minimum of three comparable written bids when sufficient vendors are available.

D. If the individual or Family Care provider is having other renovations done to the house simultaneously with the environmental modifications, the scope of work should **clearly delineate the environmental modifications from the other work that cannot be billed to Medicaid.**

E. When the estimates or bids have been obtained, the individual, advocate or Family Care provider sends the estimates or bids, and name of the lowest responsible bidder to the DDSO or the voluntary provider who is an approved provider of environmental modifications. Voluntary agencies must notify the DDSO of the estimates/bids and the chosen vendor. The service coordinator should provide assistance in this process when needed, and should be notified when this information is submitted.

F. The DDSO or voluntary provider reviews the information to ensure adherence to the standards and definitions in the Key.

G. The DDSO will send written approval and a copy of the proposed contract, or disapproval of the proposed environmental modifications to the individual/advocate, Family Care provider or the voluntary agency, and the service coordinator. Disapproval notices must include reasons for the decision.

1. Working through the DDSO: The Family Care provider or individual/advocate will contract directly with the DDSO for reimbursement of the costs. If necessary, the payment schedule will allow people to voucher for expenses based on partial billing for costs such as supplies and materials.

   The DDSO staff must complete the appropriate forms and submit them to the OMRDD Budget Office when the job has been completed. This form will be used by New York State to bill the federal government for Medicaid funds under the HCBS waiver program. All cost documentation must be maintained by the DDSO for audit purposes.

2. Working through a voluntary agency: The voluntary agency contracts directly with the DDSO for reimbursement of the cost of services provided by the vendor to the individual based on lowest reasonable bid. The voluntary agency provides reimbursement, in turn, to the Family Care provider or individual/advocate. The contract - available from the DDSO - should be used by any party (Family Care provider, individual/advocate, or voluntary agency) seeking reimbursement directly from OMRDD.

H. Contracts, once signed, must be returned to the DDSO by the individual, advocate, Family Care provider, or voluntary agency.

1. Contracts under $15,000 are fully executed upon signing by the DDSO director and should be submitted to Central Office for processing.

2. Contracts of $15,001 or more must follow standard contract processing procedures. These contracts are fully executed upon approval by the Office of the State Comptroller.

3. Copies of fully executed contracts must be sent to the provider by the DDSO.

I. The Family Care provider, individual, advocate or voluntary agency can claim reimbursement by submitting a New York State Standard Voucher (AC 92) and a copy of the paid receipt to the DDSO upon completion of the work.

The DDSO must indicate approval for payment by writing Approved for Payment and signing on the face of the voucher under Description. The voucher and paid receipt must be attached to substantiating documentation in a form prescribed by the DDSO and submitted by the DDSO for processing. A completed Authorization Form must accompany each voucher. If necessary, the payment schedule will allow people to voucher for expenses based on partial billing for costs such as supplies and materials. This will speed up the payment process for some expenses.

Rev. April 2001	FAMILY CARE ADAPTIVE DEVICES (ASSISTIVE TECHNOLOGY)	Policy 10.11.02

Adaptive devices are aids, controls, appliances, or supplies that are necessary to enable the person to increase or maintain his or her ability to live at home and in the community with independence and safety. They assist the person in the performance of self-care, work, play/leisure activities and/or physical exercise. *Adaptive devices must be a part of the person's individualized service plan.* In order to be consistent with federal terminology, the term "assistive technology" is used to categorize both environmental modifications and adaptive devices.

The individualized service plan must reflect the provision of these assistive technology services. It must indicate where they are being obtained, such as through residential or day habilitation service under the waiver, Medicaid state plan services, generic services or natural supports.

1. Allowable Adaptive Devices

A. Communication aids and devices, including:

I. Personal emergency response systems are electronic devices that enable high-risk individuals to secure help in the event of an emergency. They include portable "help" buttons to allow for mobility. *Please note that some Personal Emergency Response Systems (PERS) are covered under Department of Social Services regulations and administered by the county.*

II. Augmentative Communication Devices* such as:

a. Direct selection, alphanumeric, scanning and encoding communicators.
b. Speech amplifiers.
c. Electronic speech aids/devices.

III. Voice, light or motion activated electronic devices.*

B. Adaptive aids and devices including:

I. Standing boards/frames.*

Ref. *The Key To The Home and Community Based Services Waiver: A Provider Guide*. April 2001

II. Adaptive switches/devices.*

III. Feeding, dining, and meal preparation aids/devices/ appliances.*

IV. Specially adapted locks.

V. Motorized wheelchairs.*

VI. Guide dogs and similar trained animals.

VII. Electrical/hydraulic and manual lifts and ramps and ancillary equipment or modifications necessary to guarantee full access to and safety in a motor vehicle. For example,

a. Wheelchair and individual restraint systems.
b. Electrical safety interlock devices for lifts (transmission, ignition, etc.).
c. Stretcher stations (restraints, tautens).
d. Structural vehicle modifications (door height, door width, interior headroom, roof height, etc.).
e. Interior grab bars.
d. Skid-resistant floor coverings.
e. Exterior and interior lighting, and flip seating for ambulatory passengers who may be accompanying the person.

VIII. Computer hardware and software that are used to assist a person with improving communication and/or adaptive skills.

IX. Adaptive aids and devices, other than the above, which would not otherwise be covered by the State Medicaid Plan.

X. Cost-effective custom-fitting, maintenance and repairs to adaptive devices are also allowable (ref. Waiver Manual for more detailed information).*

*These devices/services may be covered under the Medicaid State Plan in the category of durable medical equipment (DME). A physician's prescription for the adaptive device is required. The item must then be acquired through approved Medicaid vendor who submits a claim to the District MMIS Office. To get the address and phone number of the local District MMIS Office, contact the MMIS Office in Albany.

C. Replacements – Items, worn out through normal everyday use (keyboards, switches, etc.), may be replaced by the same procedures that were followed in acquiring them originally. There may be situations where replacement or repair would be contingent on establishing a plan that would minimize the chance of repeated loss or damage.

2. Steps to Approval of Adaptive Devices

In developing the PISP/ISP, the applicant, the advocate, the service coordinator and the assistive technology expert determine if there is a need for an adaptive device

A. If it is determined that the applicant needs an adaptive device, the applicant, advocate, service coordinator, and assistive technology expert decide whether the adaptive device may be available through informal community supports or other funding resources (ref. Waiver Manual).

B. If it is determined that the HCBS waiver is the most appropriate source of funding, the adaptive device and any related services become part of the HCBS services requested in the PISP/ISP.

C. The DDSO representative, as part of the review of the PISP/ISP, determines if waiver funding is available for this service. To assist in this review, the applicant, advocate, and service coordinator must supply supporting documentation to the DDSO, including:

I. The approximate cost and date when funds are needed for the technology and any related services. This can be submitted prior to or after the applicant moves to a Family Care home.

NOTE: OMRDD will not be responsible for paying any cost of restoring a site to its original configuration or condition.

II. The enrolled participant, with the advocate and service coordinator, proceed with the steps of the **procurement process** according to where the individual lives (ref. People Living At Home or in Family Care in *The Key To The Home and Community Based Services waiver: A Provider Guide).*

3. Adaptive Devices Procurement Process for: People Living in Family Care

After the individual, advocate, and service coordinator have completed the appropriate Steps to Approval outlined above, the following steps are necessary to obtain the adaptive device and arrange for payment:

A. The Medicaid Service Coordinator will assist the individual, advocate, or Family Care provider in contacting the DDSO waiver or CSP coordinator at the DDSO. This staff person will determine what funds are available in the CSP allocation, and explain the process for securing the funds, including obtaining landlord approval in rental situations.

B. The Family Care provider, individual, or individual's family is obligated to first bill alternative coverage, such as private health insurance covering adaptive devices, before billing Medicaid under the HCBS waiver.

C. Reimbursement funding may be requested through a DDSO or voluntary agency authorized to provide adaptive devices. The DDSO or voluntary agency should be contacted, before going to bid, to review the plans. Any work done in a Family Care home must conform to Family Care certification requirements.

D. The Family Care provider, individual, advocate, or assistive technology expert will contact the vendors of adaptive devices and document price quotes or bids as specified below. The service coordinator provides assistance as needed.

E. The individual, advocate, or Family Care provider solicits quotes or bids, based on a comparable scope of work for the adaptive device, good for a minimum of 180 days, as follows:

I. Up to and including $5,000, selects a reliable vendor (taking steps necessary to ensure reasonable pricing including documentation that at least three (3) telephone quotes were obtained) and obtains a written quotation from the selected vendor which includes all terms and conditions of sale.

II. $5,001 and above, solicits a minimum of three comparable written bids when sufficient vendors are available.

III. When the quotes or bids have been obtained, the individual, advocate or Family Care provider sends the DDSO the written quotes or bids and name of the lowest responsible bidder. The service coordinator must be available to provide any needed assistance and must be notified when this information is submitted.

IV. The DDSO reviews the information for adherence to standards and definitions in the HCBS Provider Guide.

V. The DDSO will send written approval and a copy of the proposed contract, or disapproval of the proposed adaptive devices, to the individual/advocate, Family Care provider and the service coordinator. Disapproval notices must include reasons for the decision.

a. Working directly with the DDSO: The Family Care provider, and individual will contract directly with the DDSO for reimbursement of the costs. Multiple payments may be made in accordance with the contract payment schedule for partial billing by the vendor, i.e., for supplies and materials.

The DDSO staff must complete the appropriate forms, and submit them to the OMRDD Budget Office when the job has been completed. This form will be used by New York State to bill the federal government for Medicaid funds under the HCBS waiver program. All cost documentation must be maintained by the DDSO for audit purposes.

b. Working through a voluntary agency: The voluntary agency contracts directly with the DDSO for reimbursement of the cost of services provided by the vendor to the individual based on lowest reasonable bid. The voluntary agency provides reimbursement, in turn, to the Family Care provider or individual or advocate. The contract-available

from the DDSO-should be used by any party (Family Care provider, individual, advocate, or voluntary agency) seeking reimbursement directly from OMRDD.

F. Contracts, once signed, must be returned to the DDSO by the individual, advocate, Family Care provider, or voluntary agency.

I. Contracts under $15,000 are fully executed upon signing by the DDSO director and should be submitted to Budget and Fiscal Services (Central Office) for processing.

II. Contracts of $15,001 or more must follow standard contract processing procedures. These contracts are fully executed upon approval by the Office of the State Comptroller.

III. Copies of fully executed contracts must be sent to the provider by the DDSO.

G. The Family Care provider, individual, individual's family, or voluntary agency can claim reimbursement by submitting a New York State Standard Voucher (AC 92) and a copy of the paid receipt to the DDSO upon completion of the work.

The DDSO must indicate approval for payment by writing "Approved for Payment" and signing on the face of the voucher under "Description." The voucher and paid receipt must be attached to substantiating documentation in a form prescribed by the DDSO and submitted by the DDSO to OMRDD for processing. If necessary, the payment schedule will allow people to voucher for expenses based on partial billing for costs such as supplies and materials.

FOR MORE DETAILED INFORMATION AND FORMS, CONTACT YOUR DDSO

June 1998	FAMILY CARE LOANS TO ASSIST WITH LEASING	Policy 10.11.3

OMRDD has budgeted a limited amount of funds and has created a financing procedure to assist current Family Care providers who want to increase the certified capacity of their home by leasing another location for certification (to replace the current location); or to assist prospective Family Care providers in the leasing of a residence that will meet the certification requirements for a Family Care home. To assist in leasing, a loan, not to exceed $5000, may be extended by OMRDD to a Family Care provider for initial security deposit, and/or the first and last month's rent payment when the lease requires such deposit or repayment.

The assistance on the part of OMRDD is based on the availability of funds, and a provider's willingness, and commitment to provide services to an individual or individuals with developmental disabilities. The funds do not constitute an entitlement to Family Care providers or individuals. It is assumed that the provider will choose to continue to deliver Family Care services for the life of the contract and will, therefore, not be obligated to repay the loan. The sponsoring agency will determine the appropriateness of, and give initial approval on requests for loans to assist with leasing.

A Family Care provider may make a request for a loan to assist with leasing for a maximum of $5000. The financing procedure establishes a loan repayment schedule that OMRDD may forgive in whole or in part, based on a provider's continued participation in the Family Care Program. The schedule for repayment of the loan will be determined by the size of the loan, the history of service of the Family Care provider, the perceived commitment of a current or potential provider, and the ability of the provider to provide Family Care services. It is recommended that the repayment schedule for any loan of $4000 or less, or the first $4000 of a larger loan, be for a two-year period. The schedule for repayment will be established by a provider loan contract, and the contract will allow the forgiveness of the loan in an amount equal to each monthly payment as long as the home remains certified and the provider provides services to an individual with developmental disabilities selected by the DDSO. A contract, developed by the Office of Counsel, is to be used. Contracts will be executed by the DDSO. If circumstances dictate the need for a change in or addition to a contract, the Office of Counsel is to be contacted for guidance. When a request for a loan is made for a lease for a *prospective* Family Care home, it will be necessary for the DDSO to issue a conditional operating certificate to the provider before the loan can be made.

In exchange for a loan to assist with leasing, the Family Care provider must agree to:

1. Maintain certification of a Family Care home for the period of the loan, and

2. Provide services to an individual or individuals with developmental disabilities selected by the DDSO for the period of the loan.

The balance of a loan to assist with leasing may be forgiven, in full, under the following circumstances when:

1. A Family Care home is certified in the name of one Family Care provider only, and that Family Care provider dies.

2. A Family Care home is certified in the name of one Family Care provider only, and that Family Care provider, because of documented illness, is unable to continue to operate the home and surrenders the operating certificate.

3. A Family Care provider can demonstrate hardship as a result of death; illness or other crisis to a member of a provider's immediate family or to another party co-named on the operating certificate, and surrenders the operating certificate.

The Family Care provider has been granted a loan and is expected to pay the balance of the loan with appropriate interest when:

1. The Family Care home closes due to the Family Care provider withdrawing from the Family Care Program.

2. The Family Care home is closed due to decertification.

3. The Family Care provider repeatedly refuses to accept placement into the home.

The sponsoring agency must notify the OMRDD Central Office Family Care Unit, 44 Holland Avenue, Albany, New York, when a provider who has received an environmental modification loan leaves the program and the repayment provisions of the contract are implemented.

RESPONSIBILITY	PROCEDURE
Current or Prospective Family Care Provider	1. Notifies Family Care Home Liaison of the sponsoring agency of willingness to provide services to an individual or individuals with developmental disabilities. This is to be done at an identified location for which a lease is required. This provider then documents the amount needed for a security deposit and/or firs and last month's rent (e.g., a letter from prospective landlord, copy of unsigned propose lease).
Sponsoring Agency and DDSO	2. Evaluates the capacity and occupancy of the DDSO's Family Care Program to determine the need for the loan 3. Inspects site to determine if it will meet certification requirements. 4. Evaluates situation: a. If lease is for current Family Care provider: reviews appropriateness of move to increase the capacity. b. If lease is for prospective Family Care provider: determines if applicant will be accepted as a provider. c. Identifies the level or reimbursement fo services delivered to individual(s) who will reside in the home. d. Identifies any other assistance needed to open the home (e.g., environmental modifications).

5. On the basis of such review, recommends approval or disapproval of the request, and forwards the request to the OMRDD Central Office Family Care Unit with justification and copies of quotes/estimates, indicating the one that has been accepted.

Central Office Family Care Uni

6. Advises sponsoring agency and DDSO whether to proceed with the request for the Family Care loan to assist with leasing.

DDSO

7. Decides, on the basis of Central Office Family Care Unit review whether or not to issue a conditional operating certificate to prospective provider, and/or approve or disapprove the request for the loan. If approved:

   a. Establishes the repayment schedule fo the provider.

   b. Draws up provider loan contract.

   c. Charges against the Community Services Plan (CSP) or the base allocation, as appropriate, and for:

      (1) Processes, $1000 or less, the provider loan contract and provides funds through the "quick pay" process at the DDS Business Office.

      (2) Processes, $1000.01-$5000 of CSP funds, the provider loan contract through the DDSO Business Office.

      (3) Sends, $1000.01-$5000 of the base allocation, the provider loa contract for processing and fisca

approval to the Central Office Budget Office (NOTE: can advis Budget Office of expected expenditure in advance of sending provider loan contract).

8. Advises sponsoring agency and provider as to status of Family Care home certification, if applicable, and the status of the request for th loan.

Sponsoring Agency with Family Care Provider

9. Notifies landlord of status, and obtains commitment for a lease.

DDSO

10. Through the sponsoring agency, obtains Family Care provider's signature on contract.

11. Obtains DDSO director's signature on contract

12. Notifies Family Care provider in writing whe the provider loan contract has been approve and that the lease may be signed, and return original contract to the provider. Includes i letter of notification the following:

    a. Amount of loan for leasing.

    b. Identification of contact at DDSO.

13. Notifies the sponsoring agency by sending copy of the notification letter and a copy of th provider loan contract.

Family Care Provider

14. Signs lease, using DDSO letter to substantiat commitment for required payments.

DDSO Family Care Coordinator

15. Obtains copy of lease through sponsorin agency Family Care Coordinator, if applicable or Family Care provider.

	16.	Submits copy of lease, and Standard Vouche (AC-92) to the DDSO business office.
DDSO Business Officer	17.	Reviews voucher for accuracy, and obtain signature from the DDSO director (o designee).
	18.	Codes voucher according to business offic procedures, and submits the voucher to th Office of the State Comptroller for payment.

December 2000	FAMILY CARE LOANS FOR DOWN PAYMENT AND/OR RENOVATIONS	Policy 10.11.4

OMRDD may provide Family Care Home Loans to existing or potential providers who wish to acquire homes that will be certified as family care homes (Down Payment Loans). OMRDD may provide family care home loans to potential providers when the present home or present residence cannot meet the needs of the individual(s) who do or will reside there or who wish to renovate or otherwise modify or alter a home to meet OMRDD's initial certification requirements. *The maximum amount available to the operator(s) of a Family Care home for a Family Care Home Loan (whether for a down payment or renovation or both) is limited to $20,000.* **The funds do not constitute an entitlement for a Family Care provider or an individual.**

I. Down Payment Loans:

The Down Payment Loan Program is designed to assist a potential or existing provider to acquire a home that will be certified as a Family Care home in that provider's name. In applying for a down payment loan, a provider must furnish sufficient documentation identifying the property selected by the provider and approved by the DDSO, the purchase price, the amount of any mortgage to be obtained from a bank, the amount of money, if any, to be supplied by the provider towards the purchase and the amount of the requested down payment loan. If the provider intends to obtain a mortgage from a bank, the provider must provide a letter from the bank indicating its willingness to approve the mortgage application of the provider, pending receipt of the down payment.

In most instances the down payment loan proceeds from OMRDD will not be issued unless and until the provider actually acquires the property. However, if the provider requires a down payment loan to secure the property by binder or contract prior to acquisition of the property, the provider must contact the DDSO to see what arrangements can be made to allow for release of the proceeds, or some portion thereof prior to acquisition. When a prospective Family Care provider makes a request for a down payment loan, it will be necessary for the DDSO to issue a conditional operating certificate before the loan can be made.

The New York State Office of Mental Retardation and Developmental Disabilities will establish a security interest on the property purchased with the down payment loan. The security interest will be in the form of a second mortgage on the property and will remain in effect until the loan is forgiven or repaid.

II. Renovation Loans:

The Renovation Loan Program is designed to assist a potential or existing provider to make renovations, or other such modifications or alterations necessary to maintain or obtain certification when the provider has submitted documentation to the DDSO that he or she has exhausted all other funding alternatives.

The sponsoring agency and the DDSO will work with the provider to determine the extent of the work that will be necessary. A request for a renovation loan must be accompanied by three or more written competitive bids, or, for loans of $500 or less, by three estimates (which may be made by telephone) or written estimates (or a combination of both). The lowest responsible bidder must be accepted. When the cost of the materials and/or work to be done exceeds $1,000, the General Business Law, Article 36-A, *Home Improvement Contracts*, §770, requires that there be a vendor contract and vendor must be duly licensed, if applicable. This vendor contract would be between the contractor and the Family Care provider. A request for a renovation loan must be approved by the DDSO, and the plans, and completed work is to be reviewed by DDSO staff qualified to do so to ensure meeting certification requirements. When a prospective Family Care provider makes a request for a renovation loan, it will be necessary for the DDSO to issue a conditional operating certificate before the loan can be made.

The New York State Office of Mental Retardation and Developmental Disabilities will establish a security interest on renovated property when the cost of the renovation is $5,000 or more, and when the renovations are not directly related to an individual's needs, (e.g., Environmental Modifications). The security interest will be in the form of a second mortgage on the property and will remain in effect until the loan is forgiven or repaid.

III. General Principles and/or Guidelines:

The assistance on the part of OMRDD is based on the availability of funds, and a provider's willingness, and commitment to provide services. The funds do not constitute an entitlement. It is assumed that the provider will choose to continue and be legally able to deliver Family Care services for the life of the contract. For each month that the Family Care provider maintains a valid operating certificate and provides Family Care services to individuals, residing in the home, the provider will not have to make that month's payment as provided for in the contractual repayment schedule. The sponsoring agency will determine the appropriateness of the loan. Central Office Family Care Unit gives final approval for a Family Care Home Loan after review of:

1. The documented need(s) of the individual(s) who resides or will reside in the Family Care home.

2. The length of service by the Family Care provider and history of the provider.

3. The total number of individuals served or to be served in the Family Care home.

4. The review of existing DDSO Family Care capacity needs.

5. The adherence with stated intent of the Family Care loan program.

6. The adherence to specified funding limits.

A Family Care provider may request a Family Care Home Loan for a maximum of $20,000. The financing procedure establishes a loan repayment schedule that OMRDD may forgive in whole or in part, based on a provider's continued participation in the Family Care Program. The schedule for repayment of the loan will be determined by the size of the loan, the history of service of the Family Care provider, the perceived commitment of a current or potential provider to the Family Care Program and the ability of the provider to provide Family Care services. It is recommended that the repayment schedule for any loan of $4000 or less, or the first $4000 of a larger loan, be for a two-year period. After the first $4000, the maximum amount of a loan that can be repaid in one year is $4000.

The schedule for repayment will be established by a provider loan contract, and the contract will allow the forgiveness of repayment of a portion of the loan in an amount equal to each monthly payment as long as the home remains certified and the provider continues to provide services.

A provider loan agreement, developed by Office of Counsel is to be used. Provider loan contracts will be executed by the DDSO but if the amount is greater than $10,000, then approval of the control agencies will be required. Sufficient time must be allowed for this approval, as the loan proceeds will not be available until all approvals are obtained. If circumstances dictate the need for a change in or addition to the provider loan contract, the Office of Counsel is to be contacted for guidance.

When a request for a loan is made for a *prospective* Family Care provider or home, it will be necessary for the DDSO to issue a conditional operating certificate to the provider before the loan can be made. If the property is leased, the DDSO will confirm the appropriateness of the proposed renovations(s) and ensure that there is written approval from the landlord. In instances where the cost of renovation to property is $5,000 or more and when the renovation is not directly related to the needs of the individual (i.e., Environmental Modifications), the New York State Office of Mental Retardation and Developmental Disabilities must establish a security interest on the property. If the owner of leased property will not consent to such an interest, then OMRDD will not approve a loan. In exchange for the loan, the Family Care provider must agree to:

1. Maintain certification of the Family Care home at the same site for which the loan was made for the period of the loan; and

2. Provide services to individuals with developmental disabilities selected by the DDSO, for the period of the loan.

The balance of a loan may be forgiven, in full or in part, under the following circumstances when:

1. A Family Care home is certified in the name of one Family Care provider only, and that Family Care provider dies.

2. A Family Care home is certified in the name of one Family Care provider only, and that Family Care provider, because of documented illness, is unable to continue to operate the home and surrenders the operating certificate.

3. A Family Care provider can demonstrate hardship as a result of death; illness or other crisis to himself and/or herself a member of a provider's immediate family and/or to another party co-named on the operating certificate, and surrenders the operating certificate.

4. A Family Care home is destroyed or, on a permanent basis, is no longer habitable, the amount which may be forgiven must be reduced by an amount equal to the insurance proceeds, if any, received by the Family Care provider in connection with the destruction or damage to the home.

The Family Care provider who has been granted a loan is expected to repay the balance of the loan, with appropriate interest, if:

1. A Family Care home closes due to the Family Care provider withdrawing from the Family Care Program.

2. A Family Care home is closed due to decertification.

3. The Family Care provider repeatedly refuses to accept placements in the home.

The provider loan contract will be negotiated by, and reviewed and signed at the DDSO. If the amount of the loan is $10,000 or more, it will then be processed through the OMRDD Contract Management Unit and applicable control agencies; once the contract has been approved by the control agencies, a voucher for the payment can be processed and the check forwarded to the provider.

If a mortgage is required the provider or their duly authorized representative (broker, attorney, etc.), must contact the DDSO. The responsibility for ensuring compliance with procedures must rest with the DDSO but Counsel's Office will be available to answer questions that are legal in nature.

The purpose of the mortgage is to protect OMRDD's investment in the property in the event the Family Care provider fails to fulfill his or her obligations in connection with the loan. The provider must always be advised to consult with an attorney prior to executing any mortgage or loan document.

The sponsoring agency must notify the Family Care Unit, OMRDD Central Office, 44 Holland Avenue, Albany, New York, when a provider who has received a home loan leaves the program and the repayment provisions of the contract are implemented.

IV. Down Payment Loans:

As general policy the DDSO is not authorized to release any portion of the down payment loan prior to the actual acquisition of the property because the loan cannot be secured by a mortgage until such time as the provider actually becomes the owner of the property. In those instances where the provider requires the down payment loan proceeds, or some portion thereof, prior to the acquisition of the property, the DDSO must consult with

Counsel's Office to ascertain what alternative arrangements, if any, can be made in order to secure OMRDD's loan.

In all instances, a title report must be ordered and the provider or the provider's attorney must be directed to order and send a copy of the title report to Counsel's Office for review and approval. Counsel's Office will contact the title company and, if applicable, the attorney for the provider and advise them that a mortgage is to be placed on the property at the time of closing in the amount of the down payment loan.

In those instances where the DDSO has been advised that the provider will be obtaining other financing to acquire the property, the mortgage to be given to OMRDD may be subordinate to such other financing. Once all approvals have been obtained, the funds for the down payment loan will be sent by the DDSO to either the provider's attorney or the title company to be held until the closing to be released only upon fulfillment of the following conditions.

1. Satisfactory title to the property as certified by the title company and as approved by Counsel's Office; and

2. Execution of the loan agreement and mortgage to OMRDD by the provider and any other record owners of the property; and

3. Issuance of title insurance in favor of OMRDD in the amount of the down payment loan.

V. **Renovation Loans:**

The procedure for the renovation loans will be slightly different where the Family Care provider is the owner, either singly or with others, or is the lessee of the property to be renovated. Prior to their disbursement of the proceeds of the renovation loan, the DDSO must advise the provider that he or she must order a title report for the property and direct that a copy of the report be sent to Counsel's Office for review and approval. The title company will serve as the agent for OMRDD and will ensure that the proceeds of the renovation loan will be released to the provider only upon fulfillment of the following conditions:

1. Satisfactory title to the property as certified by the title company and as approved by Counsel's Office; and

2. Execution of the loan agreement and mortgage to OMRDD by the provider and any other record owners of the property; and

3. Issuance of title insurance in favor of OMRDD in the amount of the renovation loan.

VI. **Mortgage Documents:**

Counsel's Office will prepare all of the documents that are to be used.

VII. **Costs and Expenses:**

The Family Care provider will be responsible for payment of all of the costs and expenses in connection with the loan and the mortgage. In addition, the provider will be responsible for the fees of his or her attorney. These anticipated costs and expenses can be included in the loan application, and funded through the loan proceeds subject to approval of the DDSO.

RESPONSIBILITY	PROCEDURE
Family Care Provider Prospective Provider	1. Notifies Family Care Home Liaison of the need for a Family Care Home Loan to purchase a prospective Family Care home and/or to make renovations to an existing or proposed home t meet certification requirements.
	2. Completes Application for Loan Down Paymen and/ or Renovation and includes documentation, where necessary, of the exhaustion of all other funding sources.
Sponsoring Agency with Family Care Provider	3. Reviews and develops justification for the loan and/or the scope of renovation work needed to ensure the home will meet certification requirements.

Sponsoring Agency with DDSO	4.	Determines if the loan request is justified and that the prospective home and/or renovations will meet certification requirements.
	5.	Submits copy of loan application together with bids and/or quotes, and any other documentation that the potential Family Care provider has exhausted all other funding sources, as well as, the justification for the loa to OMRDD Central Office Family Care Unit.
OMRDD Family Care Unit	6.	Advises the sponsoring agency whether to proceed with the request for a Family Care Home Loan, based upon reviews of material submitted by DDSOs.
Sponsoring Agency	7.	Advises the Family Care provider to proceed with request.

VIII. **FOR DOWN PAYMENT REQUEST:**

Family Care Provider	7a.	Obtains documentation from the bank in the form of a letter that identifies the total amount of money necessary for a down payment on the specific site selected.
	7b.	Orders title report and has a copy sent to OMRDD Office of Counsel.
	7c.	Notifies OMRDD's Office of Counsel of the name, address and telephone of the provider' attorney.
	7d.	Obtains documentation from the bank that it is willing to approve the mortgage application of the provider, pending receipt of the down payment.

7e. Submits request to the sponsoring agency for the amount of the down payment assistance required, with the above required documentation.

IX. **FOR RENOVATION LOAN:**

Family Care Provider

8a. Obtains three or more written competitive bids that specify compliance with all applicable State and local laws, codes, and ordinances fo renovations costing more than $1,001 ($1,001 $20,000). Separating the costs for those item that are applicable to the renovation request, should other work be included in the bid. For renovations costing $1,000 or less, three phone quotes or written estimates are acceptable.

8b. Submits all bids or quotes and/or estimates to the sponsoring agency Family Care Coordinator, indicating lowest responsible bidder selected.

Sponsoring Agency

8c. Reviews the proposed renovation(s), the justification for making them, and the viability of extending the loan to the Family Care provider

8d. On the basis of such review, recommends approval or disapproval of the request and forwards request to the DDSO with justification and copies of all bids or quotes/ and/or estimates, indicating the lowest responsible bidder that is accepted.

8e. Orders title report and has a copy sent to OMRDD's Office of Counsel.

8f. Notifies OMRDD's Office of Counsel of the name, address and telephone number of the provider's attorney.

X. **FOR ALL REQUESTS:**

DDSO

9. Evaluates the continued certification of the Family Care home, reviews all documents, an approves or disapproves the request. If approved:

a. Establishes the repayment schedule fo the provider.

b. Draws up a provider loan contract.

c. Obtains, through the sponsoring agency, Family Care provider's notarized signature on the loan contract

d. Obtains DDSO director's signature on the provider loan contract.

e. Charges against the Community Services Plan (CSP) or the base allocation, as appropriate, and for:

(i) Processes, $1,000 or less, the provider loan contract and provides funds through the "quick pay" process at the DDS Business Office.

(ii) Processes, $1000.01-$10,000.0 of CSP funds, the provider loan contract through the DDSO Business Office.

(iii) Sends, $1,000.01-$10,000.00 of the base allocation, the provider loan contract for processing and fiscal approval to the Central Office Budget Office (NOTE: can advise Budget Office of expecte expenditure in advance of sending provider loan contract).

(iv) Sends, $10,000.01-$20,000; to the Central Office Contract Management Unit for processing fiscal approval, and return of provider loan contract.

10. Advises Family Care provider in writing that th provider contract for the loan has received fina approval, and that the mortgage can be completed, and/or renovations can begin, and returns original provider loan contract to the provider. Notifies the sponsoring agency and the OMRDD Central Office Family Care Unit, by sending a copy of the letter of notification, and a copy of the provider loan contract.

Family Care Provider

11. Notifies mortgage holder to proceed; notifies bidder on renovations that a vendor contract can be drawn up and the work on the premises can be initiated.

12. For Renovations:

a. Ensures, to the extent possible, that the work is being done in accordance with the bid proposal and scope of work.

b. Notifies the Family Care Coordinator of the sponsoring agency when the work i

completed.

c. Notifies DDSO when the work is completed.

Sponsoring Agency\DDSO

d. Reviews the work to ensure that the home can be certified or maintain its certification.

e. Obtains a final bill through the sponsoring agency Family Care Coordinator, if applicable, or Family Car provider, and reviews it for conformance with bid.

DDSO Family Care Coordinator/Designee

13. Submits bill, and Standard Voucher (AC-92) to the DDSO business officer, unless other arrangements have been made through the vendor contract (i.e., progress payments).

DDSO Business Officer

14. Reviews voucher for accuracy and obtains signature from the DDSO director (or designee).

15. Codes voucher according to business office procedures and submits the voucher to the Office of the State Comptroller for payment.

16. When appropriate, establishes an interest on the improved and/or purchased property by filing with the County Clerk in the County where the property is located.

Sponsoring Agency

17. Notifies OMRDD Central Office Family Care Unit and OMRDD Office of Counsel when a provider who has received a home loan leaves the program and the repayment and/or interes provision of the contract must be implemented

FAMILY CARE
APPLICATION FOR
LOAN DOWN PAYMENT/RENOVATION

I. TO BE COMPLETED BY LOAN APPLICANT.

1. Name: _____
   Last First Middle

2. Current Address: _____

   _____
   Zip Code

   Home Phone: ( ) _____ Work Phone: ( ) _____

3. Is applicant currently employed? Yes ( ) No ( )

   If Yes, Answer 4 - 7. If No, describe source of income:

   _____

   _____

4. Firm Name: _____
5. Firm Address: _____
6. Length of time employed with this firm: _____
7. Job Title: _____
8. Job Description: _____

I.A. TO BE COMPLETED BY LOAN CO-APPLICANT.

1. Name: _____
   Last First Middle

2. Current Address: _____

   _____ Zip Code _____

   Home Phone: ( ) _____ Work Phone: ( ) _____

3. Is co-applicant currently employed? Yes ( ) No ( )

   If Yes, Answer 4 - 7. If No, describe your source of income: _____

4. Firm Name: _____
5. Firm address: _____
6. Length of time employed with the firm: _____
7. Job title: _____
8. Job description: _____

I.B TO BE COMPLETED BY LOAN APPLICANT.

1. Address of the proposed Family Care Home:

   _____

   _____

   _____ Zip Code _____

2. No. of bedrooms _____ No. of bathrooms _____ No. of floors _____

3. No. Of provider's family members currently living in the home ____ Proposed home ____

4. Other than individuals placed as part of the OMRDD Family Care Program and family members identified in #3, will any other persons reside in the proposed family care home?

   Yes ( ) No ( ) If Yes, identify below:

   Name: _____ Age: ____ Relationship: _____

   Name: _____ Age: ____ Relationship: _____

   Name: _____ Age: ____ Relationship: _____

I.C. TO BE COMPLETED BY LOAN APPLICANT FOR DOWN PAYMENT ONLY

1. Total cost of the proposed family care home: $ _____
2. Money required for the down payment: $ _____
3. Monthly mortgage payment for proposed home: $ _____
4. Monthly mortgage/rent payment for current home: $ _____
5. Where will the remainder of the down payment be obtained in the event that the loan does not cover the total amount? (Identify)

   _____

   _____

   _____

   _____

6. Number of individuals you intend to serve in the proposed home. _____
7. How long do you intend to serve individuals in the home? _____
8. Are you currently a certified family care provider? Yes ____ No ____

   If Yes, how long have you been certified? _____

   How many individuals currently reside in your home? _____

1.D TO BE COMPLETED BY LOAN APPLICANT FOR ALL RENOVATIONS ONLY.

1. Total costs of Renovations: $ _____

2. Description of Renovations: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

1E. TO BE COMPLETED BY ALL APPLICANTS

I\ we, the undersigned, understand that the OMRDD Loan Program does not constitute an entitlement and that OMRDD maintains the right to assess my/our suitability to obtain a loan under this program.

I\We understand that a loan may be made only in the event that I/We am found suitable; that the proposed dwelling is found to be a viable family care home; that this home is needed by OMRDD and the _____ _____ DDSO; and that the funds are available.

VERIFICATION UNDER OATH

STATE OF NEW YORK COUNTY OF _____

_____ and _____

Being duly sworn, deposes, and says that {(he) (she) (they)} {(is) (are)} the person(s) who {(has) (have)} executed the above loan application; that the statements in the foregoing application are true of {(his) (her) (their)} own knowledges.

Sworn to before me this _____ day of _____

_____
Notary Public

_____	_____	_____
Printed Name of Applicant	Signature of Applicant	Date
Printed name of Co-Applicant	Signature of Co-applicant	Date

1.F. TO BE COMPLETED BY LOAN APPLICANT.

LOAN APPLICATION
STATEMENT OF NEED

PLEASE DESCRIBE BELOW THE REASON(S) YOU ARE APPLYING FOR A LOAN FOR A FAMILY CARE HOME DOWN PAYMENT. DESCRIBE YOUR CURRENT SITUATION FULLY, AS WELL AS WHAT YOU INTEND TO ACCOMPLISH BY OBTAINING A LOAN. ATTACH ADDITIONAL PAGES IF NECESSARY.

Signature of Applicant Date

Rev. 10/99

II. TO BE COMPLETED BY DDSO.

1. Name of DDSO: _____

2. Address: _____

   _____ Zip Code _____

3. Contact Person: _____

   Title: _____ Phone: ( ) _____

4. Address of proposed home: _____

   _____ Zip Code _____

5. Name of individual(s) who are expected to reside in the home:

   A. _____ B. _____

   C. _____ D. _____

6. Describe the proposed home, giving details about appropriateness for the individual(s) identified above:

   _____

   _____

   _____

   _____

7. Bank to which applicant has submitted mortgage application:

   Name of Bank: _____

   Address: _____ Zip Code _____

8. Will renovations/modifications be requested? Yes _____ No _____

   If Yes, describe below giving clinical justification(s) and approximate cost:

   _____

   _____

   _____

   _____

   _____

   _____

   _____ $ _____

   Approximate Cost

9. Is bank letter attached indicating that:

   A. Applicant appears to qualify for home mortgage? Yes _____ No _____

   B. Amount of down payment? Yes _____ No _____

   C. Estimated amount of monthly mortgage? Yes _____ No _____

10. Date application reviewed by local committee: _____

11. Date application received by CSP Committee: _____

12. Additional information required? Yes _____ No _____

    Explain: _____

13. Date of next review: _____

III. FINAL DISPOSITION:

1. Initial review:

   Family Care Coordinator: _____ Date _____

   Approve _____ Disapprove _____

2. Recommend Approval: Yes _____ No _____

   Director or designee: _____ Date _____

   Business Officer: _____ Date _____

3. If disapproved, give reason(s): _____

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cc. **Business Officer**
Provider File
Central Office Family Care Unit

SECTION 10.12

HEALTH AND MEDICAL SERVICES

10.12.1 Blood Borne Pathogens

10.12.2 Rubella

10.12.3 Hepatitis B

10.12.4 Tuberculosis

10.12.5 Human Immunodeficiency Virus (HIV)

10.12.6 Insulin Injection for Diabetes

10.12.7 Psychotropic Medications

10.12.8 Gastrostomy (G and J Tube)

10.12.9 Podiatry Restrictions

Individuals whose activities involve direct skin contact with other individual's blood or certain bodily fluids (semen, vaginal secretions, or other bodily fluids containing visible blood) must continually follow standard universal infection control precautions. Use of these precautions may minimize the potential risk of exposure and the inadvertent transmission of *Blood Borne* pathogenic organisms. These precautions are recommended for the care of all individuals in the household; but must be followed when caring for an individual with a known *Blood Borne* infection.

RESPONSIBILITY	PROCEDURE
Family Care Provider and Others	1. When direct skin contact with an individual's blood or other bodily fluids is anticipated, the provider or others must use appropriate barrier precautions. This includes wearing non-sterile gloves: a. When touching blood, mucous membranes, non-intact skin, semen and vaginal secretions, or other body fluids visibly tinged with blood. b. Or contaminated surfaces with use above. 2. Gloves must also be worn when in contact with feces or infected wounds. 3. Gloves must be discarded after contact with each individual, and hands must be washed immediately after gloves are removed. 4. Hands and other skin surfaces must be washed promptly and thoroughly if contaminated with blood or other bodily fluids or excretions.

5. Any care giver (Family Care provider, respite provider/sitter, family members, etc.) with draining skin lesions or weeping dermatitis must refrain from direct care until the condition resolves and a doctor's statement is received. If this is not possible, protective gloves must be worn.

6. Visible spills of blood, or other secretions, must be cleaned promptly by first removing the visible material, and disposed according to universal precaution guidelines, and then cleaning the area with an approved disinfectant or a bleach solution such as 1:10 dilution of Clorox and water. Protective gloves must be worn during cleaning procedures. If a sponge or mop is used, soak it afterward for at least 10 minutes in a bleach and water solution.

7. Used gloves and other infectious waste must be doubled bagged in waterproof plastic bags. Sharp objects to include needles, disposable razor blades, which may be contaminated with blood must be disposed of in a puncture-resistant container, i.e., coffee can.

8. Each Family Care provider is expected to purchase and maintain a sufficient supply of non-sterile latex or vinyl gloves.

OMRDD, based on 10 NYCRR Section 763.4, must ensure that a record of the following test and examinations is maintained for all Family Care providers who have direct contact with individuals. There must be immunization to Rubella consistent with good medical practice. Women of childbearing age must have a screening test, approved by the Health Department, to be followed by active immunization as appropriate.

Hepatitis B Virus (HBV) is a viral illness which affects the liver and can cause liver damage. The most significant source of transmission is exposure to blood of an individual who is a carrier or has active disease.

All Family Care providers who, within the course of their routine duties are reasonably expected to have contact with, and/or provide direct care to individuals, must be offered, at no cost to the provider, Hepatitis B immunization within 10 (ten) days of becoming certified. This vaccine is to be given in a series of three shots over a six-month period. The vaccine must be available to the provider at a reasonable time and place under the supervision of a licensed physician or another licensed health-care professional.

Sponsoring agency nursing staff must recommend to the provider and other household members that they contact their personal physician if exposure to Hepatitis B is suspected. Hepatitis B inoculations may be obtained through a local physician. For Medicaid eligible Family Care individuals, the physician must bill Medicaid directly. The sponsoring agency will be responsible for the cost of the immunization for non-Medicaid individuals. Family Care providers will be reimbursed for the series of inoculations at the current Medicaid rate. The provider must submit documentation to the DDSO verifying the expenditure. The DDSO will process a voucher using the Object Code for Hepatitis B.

All providers receiving Hepatitis B immunizations must have post-vaccination testing for serologic response. Such testing must be performed five to six weeks post-vaccination. If the provider has not circonverted, the full series will be administered.

Pre-vaccine serologic testing (blood test for pre-existing immunity to Hep B) is not necessary but may be considered for those new providers who were in previous occupations involving significant blood exposure, such as emergency room nurse, dental hygienist, direct care provider in private facility for persons with developmental disabilities. These providers may have existing antibody to Hepatitis B negating the need for vaccine. Newly certified providers who were not in such occupations are not likely to have existing antibody and do not need to have a pre-vaccine serologic test.

Family Care providers may decline the vaccine if they so choose. Providers declining the vaccine **must sign a refusal statement**. These providers must be asked to participate in a Hepatitis B screening to determine their status. The sponsoring agency must be willing and able to cover providers who initially declined the vaccine but later request immunization.

Each sponsoring agency is required to conduct training on the vaccine efficacy, safety, methods of administration and benefits must be provided to all newly certified Family Care providers. Training records must be maintained for three (3) years beyond the date that the training occurred.

The signs and symptoms of Viral Hepatitis are:

Fatigue	Malaise	Arthralgia
Headache	Anorexia	Photophobia
Pharyngitis	Cough	Coryza
Nausea	Vomiting	Alterations in sense of taste and smell
Fever	Dark Urine	Mild weight loss
Yellow scleras	Jaundice	Upper right quadrant pain
Enlarged liver		

A contact can be exposed through open areas in the skin, through ingestion of blood (bites), or via percutaneous puncture of the skin. If such occurs, prophylaxis with Hepatitis B Immunoglobulin can be considered. Salvia is much less infective and would require its inoculation into the bloodstream, such as would occur with a bite, to be potentially harmful.

Therefore, some individuals who may experience few, if any, medical symptoms may be carriers. Medical symptoms usually appear from two to six months after initial exposure to this virus. This virus can be found in blood and bodily fluids several weeks prior to medical symptoms appearing, and may persist several months thereafter.

To prevent the spread of Hepatitis B in the Family Care home environment, the Family Care provider, if in contact with the individual's blood, bodily fluids, and fecal material, must observe certain personal protective precautions as necessary.

The following control measures are recommended to help prevent the spread of this virus for individuals who are Hepatitis B carriers:

1. Scrupulous personal hygiene must be followed by both individuals and Family Care providers at all times.

2. Personal toiletry items cannot be shared. Specifically, this includes razors, towels, toothbrushes, clippers or scissors used for cutting finger and toenails, or any other item, which might be blood, contaminated. If the individual shaves, an electric razor must be provided for their personal use.

3. No special procedures need be observed for disposal of feces or soiled diapers from HBsAg+ individuals. However, strict observance of good sanitary practices and laundering methods should be employed. Blood soiled items such as sanitary napkins should be handled with appropriate caution (use of gloves and careful washing of hands afterwards). Vinyl or latex gloves must be worn when in contact with blood, non-intact skin, when handling or touching surfaces contaminated with visible blood, feces or when handling bedding which may be contaminated with semen.

4. All HBsAg+ individuals can participate in swimming, except in the presence of menstruation or open wounds.

5. All individuals' eating utensils and dishes must be washed in a dishwasher or the individual must have their own dishes.

6. The individual may require a private room, particularly necessary if the patient practices poor hygiene.

7. Thorough and frequent hand washing prior to, and after donning vinyl or latex gloves cannot be stressed enough.

8. The individual should not donate blood or have sexual relations during this course of illness.

October 2000	FAMILY CARE TUBERCULOSIS	Policy 10.12.4

In accordance with 14 NYCRR Section 635-8.2(a)(3)(iii)(a), Procedures for the Control of Tuberculosis, Family Care providers who have contact with individuals must receive an annual PPD (Mantoux) skin testing within 12 months of the initial documented test results or as soon as possible, as part of their annual health status assessment. Prior to being certified as a Family Care provider, all applicant(s) must submit a medical statement verifying that he or she received a PPD within the last 12 months.

Refusal by a provider to be tested or evaluated for active tuberculosis must be considered incompatible with his or her Family Care operating certificate, unless the provisions of subdivision (a)(4) is applicable. This subdivision states that "the only allowable exclusions are prior documented significant reaction to PPD (Mantoux) testing, adequate treatment for active tuberculosis disease, or completion of adequate preventive therapy. A physician's statement of other contraindication must be acceptable as long as the statement includes a recommendation as to when and if testing would be appropriate in the future, and how the provider should be evaluated for active tuberculosis."

If a provider tests positive for tuberculosis, the DDSO must follow procedures outlined in 14 NYCRR Section 635-8.2.

Family Care providers must have annual education regarding tuberculosis including:

1. The purpose and value of periodic skin testing.

2. The timely recognition of signs and symptoms of active tuberculosis and the requirements and process to report such symptoms to DDSO staff and health care professionals.

3. The procedures and techniques for prevention of transmission of tuberculosis, including the use and benefits of infection control and environmental control techniques.

4. The importance of preventive therapy for those infected with tuberculosis.

5. The encouragement of providers infected with tuberculosis to seek HIV counseling and testing.

June 1998	FAMILY CARE HUMAN IMMUNODEFICIENCY VIRUS (HIV)	Policy 10.12.5

In accordance with 14 NYCRR Section 633.19, it is the policy of OMRDD that any information about anyone applying for services, or admitted and receiving services, is to be held in confidence. Any information obtained, or to be disclosed is to be done so with the understanding that the information is confidential and is to be maintained exclusively for the purposes of program planning and the provision of competent and humane care to that individual. Such individual specific information should only be judiciously disclosed in accordance with law for the purposes of increasing the understanding of other care providers about an individual's needs and then only care providers who have or will have responsibilities in addressing that individual's needs.

The Family Care provider must ensure confidentiality of information in their possession concerning whether an individual has been the subject of a Human Immunodeficiency Virus (HIV) related test, or has HIV infection, HIV related illness, or Acquired Immunodeficiency Syndrome (AIDS - disease of the immune system); or any information indicating an individual's possible exposure to HIV, which is "transmitted through the blood or semen of an infected person, primarily during sexual intercourse or through the sharing of IV-drug needles or blood transfusion. Most children who develop AIDS are infected by their HIV-infected mothers in the womb or through breast-feeding."

Access to HIV related information is not available in the ordinary course of business. Access may be available if the person has been trained in matters of confidentiality and related issues. Access to the HIV related information is reasonably necessary under the following circumstances:

1. To provide for the appropriate care and treatment of an individual as described in his or her Individualized Service Plan (ISP) except when the sole purpose of accessing the information is to monitor or limit behaviors that could result in significant risk contacts. The team, in consultation with the individual, has determined that he or she exhibits the capacity and willingness to manage his or her behavior so that the monitoring or limitations are not necessary.

2. In connection with an investigation of an alleged violation of an individual's rights, including discrimination or abuse.

3. To fulfill a specific statutory duty.

4. In connection with a review of the quality of care rendered by the Family Care provider.

5. To determine eligibility for services or reimbursement of services by OMRDD or the medical assistance program (Medicaid).

OMRDD must protect the confidentiality of HIV related information and must inform Family Care providers of the following written requirements:

1. HIV related information must not be examined, removed or copied by any person unless authorized under paragraph (3) of 10 NYCRR Part 63, or Article 27-F of the Public Health Law.

2. HIV related information must not be disclosed to or discussed with anyone unless that person is legally authorized to receive the information and has the need to access the information.

3. The use of markers on the face of clinical files, lists posted on walls, or other codes or displays for the sole purpose of identifying persons with HIV infection is prohibited.

4. All disclosures, oral or written, except as identified below, must be accompanied by the following statement:

This information has been disclosed to you from confidential records, which are protected by State Law. State Law prohibits you from making further disclosure of this information without the specific written consent of the individual to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure. Any unauthorized further disclosure in violation of State Law may result in a fine or jail sentence or both.

5. A violation of these confidentiality provisions may lead to suspension or dismissal from the Family Care Program, criminal or civil prosecution or both.

The OMRDD must enforce a program that will prevent the transmission of HIV infection, should a provider be exposed to the virus. The program must include requiring sound and appropriate health care practices in the care of all individuals including:

1. Training for individuals and providers on the use of protective equipment, preventive practices, and circumstances that constitute significant risk exposure.

2. Appropriate training, counseling, and supervision of individuals regarding behaviors which pose a danger for HIV transmission.

3. Training, counseling, and supervision of individuals who may be in situations that expose them to behaviors, including high risk sexual or other contact situations with others.

4. The use of accepted protective practices to prevent skins and mucous membrane exposure to blood, other body fluids, or other significant risk of body substances.

5. The use of accepted preventive practices while handling instruments or equipment that may cause puncture injuries.

6. The provision, as appropriate, of personal protective equipment that is of appropriate quality and quantity.

The sponsoring agency must ensure that no individual being served or anyone being considered for services is discriminated against, abused or otherwise treated adversely because of his or her status as one who is subject of an HIV related test, or who is thought to be, or who is, HIV infected. Discrimination includes, but is not limited to, the denial of appropriate services, isolation, quarantine, or the restriction of rights, solely because the individual or other party has or is thought to have HIV infection.

June 1998	FAMILY CARE INSULIN INJECTION	Policy 10.12.6

Diabetes is a condition that affects the way the body uses food. During the normal digestion process, the body converts food into glucose (sugar) to be used by the body cells as a source of energy. In order for glucose to get into the bodys cells, the body needs insulin, a hormone produced by the pancreas gland. In people with diabetes, insulin is either absent or lacking, or the body does not respond to the insulin that is produced. As a result, the body cannot use glucose for energy and it begins to build up in the blood creating high sugar levels in the body.

The warning signs of Type I Diabetes (insulin-dependent diabetes mellitus -IDDM):

1. Frequent urination
2. Excessive thirst
3. Extreme hunger
4. Unusual weight loss
5. Irritability
6. Weakness and fatigue
7. Nausea and vomiting

The warning signs of Type II (non-insulin-dependent diabetes mellitus- NIDDM)

1. May develop slowly
2. Any of the symptoms of IDDM and/or recurring or hard-to-heal skin, gum or bladder infections
3. Fatigue
4. Blurred Vision
5. Tingling or numbness in hands or feet
6. Itching

For those individuals that are insulin dependent, Family Care providers are permitted to administer insulin injections for diabetes through the Nurse Practice Act under the Education Law, Article 139, Nursing, Section 6908, Exempt Persons.

Whenever possible, individuals should be encouraged to self, administer insulin by injection based on the recommendation of the physician, the physician assistant or the registered nurse. The Family Care provider who is trained in medication administration, and who is trained to administer insulin for diabetes, may do so in accordance with the prescribing practitioner's instructions.

The Family Care provider must be able to recognize and respond appropriately to diabetic shock or coma. Symptoms: may include hunger, pale complexion, weakness, dizziness, irritability, headache, tremors, changes in mood or behavior, sweating and rapid pulse - if not treated it can cause loss of consciousness. Treatment commonly involves quickly restoring glucose levels to normal with a sugary food or beverage such as cola, orange juice, candy, or glucose tablets. The provider must also be informed as to the symptoms, which may indicate a need to contact the physician.

Training specifically in administering insulin and the management of the disease must be provided by a Diabetes Educator associated with a program certified by the American Diabetes Association or a hospital. The Family Care provider is not mandated to provide insulin by injection. If the provider refuses or is unable to give the services, and the DDSO cannot access a staff to administer the medication or access public health services, it may be necessary to move the individual to another home to secure appropriate and necessary medical services.

(Reference: "Diabetes: An Overview", *NIDDK Home Page*, NIH Publication No. 96-3873:1996)

When an individual in Family Care requires psychotropic medications, the Individual Service Plan (ISP) is developed with input from the team, the individual and the advocate. The ISP should be consistent with 14 NYCRR Section 633.17 (a)(18)(ii)(a), and 14 NYCRR Section 633.11 (a) (1) in that at least semiannual, or more frequently as proposed by a physician, there is a documented evaluation of the individual for an assessment of any medication adverse and/or side effects. There should be informed planning with the individual, the advocate, the provider and the Medicaid Service Coordinator (MSC). They should be given an explanation and written information of the risks and benefits of the medication.

The use of psychotropic medication is presented as an appropriate integral part of the ISP, in conjunction with other clinical interventions, including those interventions designed to address the maladaptive behavior(s) for which the medication is prescribed. The individual has the right to object to the use of psychotropic medications after he or she has been informed of the benefits and possible side effects. If there is no consent or the individual lacks the ability to consent, informed consent maybe obtained for those individuals who are residents of programs sponsored or certified by OMRDD as follows:

(a) If the individual is less than 18 of age, consent must be obtained from a parent, a guardian lawfully empowered to give such consent, or from a surrogate decision making committee pursuant to Article 80 of the Mental Hygiene Law, and regulations promulgated there under. If no such parent, guardian or surrogate decision-making committee is available or willing to consent, no professional medical treatment must be initiated without a court order.

(b) If the individual is 18 years of age or older, but lacks the capacity to understand appropriate disclosure regarding propped professional medical treatment or a determination of insufficient capacity has been made pursuant to clause (d) of this subparagraph, informed consent to such proposed professional medical treatment must be obtained from a guardian lawfully empowered to give such consent, an actively involved spouse, an actively involved parent, an actively involved adult child, a surrogate decision making committee or a court of competent jurisdiction. Consent must be sought for the proposed professional medical treatment from parties on this list in the order stated (Refer to 14 NYCRR Section §633.11 (a)(1) (iii).

The effectiveness of the medication is reevaluated at the plan review and consideration is given to pursuing the reduction of the medication to the minimally effective dose, eliminating the medication, or changing it to a less toxic one.

The ISP must define the medication(s) that are being recommended, and how the medication(s) fit within the individual's total Individualized Service Plan.

Rev. December 2000	FAMILY CARE G-TUBE FEEDING	Policy 10.12.8

Through an exemption in the New York State Education Nurse Practice Act, Family Care providers are permitted to perform nursing procedures such as Gastrostomy (G-Tube) or (J -Tube) feedings.

It is the responsibility of the Registered Professional Nurse (RN), based on the services to be performed, the skill and experience of the persons involved, the needs of the individual, and any other relevant facts, to ensure that the Family Care provider has been trained to perform G-Tube or J-Tube feedings. The nurse must determine the level and frequency of oversight, monitoring and observation needed prior to the start of the G or J Tube feedings by the Family Care provider. The Registered Nurse must also ensure that a written procedure is present. Each written procedure must address the issue of how (G or J-Tube) care will be delivered in the absence of the Family Care provider.

All training attended by the Family Care provider must be documented in the provider's file.

The State Department of Social Services implemented a provision of Chapter 14 of the Laws of 1992 restricting podiatry services.

Effective February 1993, Medicaid will no longer pay for podiatry services for recipients 21 years of age or older who do not have Medicare coverage and obtain services directly from privately practicing podiatrist.

Medicaid will continue to make payments for medically necessary foot care provided by privately practicing podiatrists for only the following populations:

1. Services to children under 21 years of age upon the written referral of a physician, physician's assistant, nurse practitioner or nurse midwife.

2. Services to Medicaid recipients who also have Medicare coverage.

Medicaid will continue to pay for podiatry services at clinics or in medical facilities, e.g., nursing homes. Additionally, Medicaid will continue to pay for medically necessary items and supplies ordered by private practicing podiatrists.

Not-for-profit operators of residential facilities are responsible for the cost of medical treatment, including podiatry not reimbursable by Medicaid, Medicare or health insurance. All payments are to be at the Medicaid Fee Schedule regardless of whether or not Medicaid is the payor.

SECTION 10.13

TRAINING

OMRDD's DDSOs will require Family Care applicants to complete a minimum of *30* (thirty) hours of training as a prerequisite to initial certification and issuance of an Operating Certificate for Family Care. Additionally, at least (24) twenty-four hours of cumulative training is required over a period of (3) three years for each certified Family Care provider. The sponsoring agency may, however, require additional training based on the needs of the individual, as well as, on the needs of the provider. Training may be held in the home of the provider or a site and time convenient for participants. The Family Care Coordinator or sponsoring agency designee will be responsible for insuring that all applicants and all providers complete initial, and ongoing training in a timely manner. Family Care providers are encouraged to take advantage of training offered in the *Catalog of Work Force Development Programs*. Providers may register online at www.omr.stste.ny.us or obtain a copy of the catalog from the local DDSO.

Certified Family Care providers, as well as, respite providers, must be able to perform the Heimlich Maneuver on a conscious or unconscious individual. Often, 911 cannot reach the home in time to save the individual's life. Those providers, who were once certified in CPR, and cannot successfully complete the course or cannot perform the Heimlich Maneuver, due to health, age or other reasons, must have a current physician's medical exemption on file. These providers must, however, attend the CPR training. Based on an objection of the family or clinical staff, the sponsoring agency may choose not to place a child and/or adult in the home.

Family Care providers must be able to understand and implement the Residential Habilitation Plan. The provider must be able to read, write, understand and carry out directions and instructions, record messages and keep simple records. Those providers, who are unable to read or write or understand English, should be provided plans, instructions and directions in their primary language, as well as, be encouraged to enroll in English as a Second Language (ESL) course.

The initial, cumulative and additional training will consist of, but not be limited to the following topics (the Asterisk "*" indicates the subject required for initial training).

1. **Initial Curriculum:**

*1. Orientation to the Agency

*2. Home and Community Based Services waiver
   a. Individualized Service Environment (ISE)
   b. An Overview of Person Centered Planning
   c. Individualized Service Plan (ISP)

d. Developmental Disabilities Profile 2 (DDP-2)
e. Residential Habilitation Services
f. Role and Responsibilities of the Family Care Home Liaison (FCHL)
g. Role and Responsibilities of the Medicaid Service Coordinator (MSC)
h. Consumer Satisfaction

*3. An Overview of Developmental Disabilities

a. Definition
b. Affects on Learning
c. Etiology and Prevention

*4. An Overview of Family Care

a. Benefits

i. Room and Board
ii. Difficulty of Care Payments
iii. Respite Service
iv. Travel Reimbursement

a. Medicaid
b. Non-Medicaid

b. Provider Code of Conduct
c. Responsibilities of Family Care Providers
d. Responsibilities of Developmental Disabilities Services Office (DDSO)
e. Record Keeping
f. Characteristics of Individuals Served
g. Consumer Benefits

i. Food Stamps
ii. Medicaid and Supplemental Security Income (SSI)
iii. Medicare and Social Security Administration (SSA)
iv. Personal Allowance
v. Clothing, Personal and Incidentals
vi. Group Purchases
vii. Other Benefits

*5. *Reportable Incidents, Serious Reportable Incidents, and Abuse* 14 NYCRR (*New York Codes of Rules and Regulations*) Part 624

a. Incident Reporting and Processing
b. Rights of Individuals, Abuse Prevention and Protection

*6. Certification

a. Child Abuse Prevention Act Requirements for Background Checks: Applicant(s) and Other Adults Living in the Home.
b. Finger Printing: Rationale and Process
c. *Family Care Home Environmental Standards* 14 NYCRR Section 635-7.4
d. *Principles Governing the Operation and Certification of Family Care Homes* 14 NYCRR Part 687
e. *Protection of Individuals Receiving Services in Facilities Operated and/or Certified* by OMRDD 14 NYCRR Part 633 (Training must include Section 633.17 -Medication Administration)
f. Safety and Security Procedures

i. Fire Drills and Escape Plan
ii. Safety Equipment
iii. Annual Safety Survey
iv. On Call System

g. Hearings (14 NYCRR Part 602)

*7. Medical Emergency Procedures

a. Cardiopulmonary Resuscitation (CPR) - One Person Rescuer
b. Heimlich Maneuver
c. First Aide Techniques

*8. Hand Washing, Infection Control and Blood Borne Pathogens

a. HIV/AIDS
b. Hepatitis B
c. Tuberculosis

II. **Ongoing Curriculum:**

1. First Aide Techniques

   a. Burns
   b. Cuts, Scrapes and Bruises
   c. Fainting
   d. Poisoning
   e. Sprains or Broken Bones
   f. Bleeding
   g. Choking (CPR/Heimlich Maneuver)

2. Health Issues/Medication Administration

   a. Prescription Medication
   b. Over the Counter Medication
   c. Drug Interaction
   d. The Role of the Family Care Provider
   e. Observing, Reporting and Recording Concerns
   f. Record Keeping
   g. Assisting with Appointments, i.e., the physician, pharmacy, etc.

3. Basic Health and Nutrition

   a. Meal Planning and Preparation
   b. Well-Balanced Diet
   c. Modified and Special Diets
   d. Consumer Involvement

4. Therapeutic Techniques

   a. Eating Skills and Therapeutic Positioning
   b. Transferring and Positioning (Lifting and Moving)

5. Principles of Human Growth and Development

6. Human Sexuality

7. Working with Dually Diagnosed Individuals

8. Coping with the Behaviorally Challenged

a. Child
b. Adolescent
c. Adult
d. Elderly

9. Coping with:

a. Grief and Loss
b. Fear and Anxiety
c. Depression and Confusion
d. Apprehension and Discouragement

10. Domestic Violence: Signs and Symptoms

11. Stress Management and Relaxation Therapy

12. Cultural Diversity

13. Specific Characteristics (of individual to be Placed)

a. General Background
b. Medical Needs/Medication(s)/Drug Interactions
c. Specific Disability
d. Program Attendance
e. Goals and Plans
f. Developing Needs
g. Medical Financial Responsibilities
h. Natural Family

14. Defensive Driving

15. Budgeting and Personal Financial Management

16. Planning for Retirement

17. Other Appropriate Topics relative to the Safety and Welfare of the Individual as may be specified by the DDSO or requested by the Provider.

III. **Specialized Curriculum:**

1. Insulin Injection for Diabetes
2. Psychotropic Medications
3. Gastrostomy (G and J Tube)
4. Trachea Tube
5. Human Immunodeficiency Virus (HIV), other Communicable Diseases
6. Coping with Alzheimer and other Neurological Disorders

FCT-2003 **DOCUMENTATION FORM**

DDSO _____ Date _____

Course Title

_____

Date _____ Length (hours) _____

Time _____ County _____

Course Code and Description

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Provider _____ Provider SSN# _____

Signature of Instructor(s) _____/_____

Organization or Title _____/_____

_____

Signature Family Care Home Liaison Date

Original: Staff Development
Copy: Provider' File

All too often Family Care providers, individuals, and sponsoring agencies find themselves in very difficult situations due to sudden need for a provider to close his or her home either temporarily or permanently. Plans are not in place to make an easy transition from one Family Care home to another or allow the individual to remain.

The Family Care Home Liaison/Medicaid Service Coordinator, and other DDSO staff must assist the Family Care provider in developing a *Family Life Plan* when informed of changing needs (retirement, sudden illness, death of a spouse) in the household (not as part of routine procedures. Short-term care is a part of on going planning in each Family care home. Family Life Plan form is an excellent resource tool for those providers considering retiring from the Program within three to five years. The plan should be updated once every three years.

The *Family Life Plan* may include:

1. Who will provide care for the individual(s) in the event of short-term provider illness?

2. Who will be available to provide long term care as the certified Family Care provider?

Family members who live in the home and have established a long term relationship with the individual(s) may be interested in providing services and may be considered because they already have a familiarity with the individual's medical, social, dietary and emotional needs, as well as an established working relationship with sponsoring agency staff.

In formulating the *Family Life Plan* (ref. attached), sponsoring agency personnel and the Family Care provider must ascertain if other family members will consider assuming provider responsibility in the home. Individuals generally accept transition more readily if provider responsibility rests with someone who is familiar to them. Sponsoring agency personnel must work closely with the provider and give supports to assist the individual(s) in transitioning to a new Family Care home, if necessary. Transition for the individual presents an emotional loss and the uncertainty of being accepted by a new family. Sponsoring agency staff must prepare the individual for the anticipated loss, whether it is from illness, retirement or death.

If the individual is in a safe environment he or she may remain in the home as long as needs are being addressed by approved family members as respite providers or sitters or another approved provider.

As part of the initial 30 hours of training for certification, or the required 24 hours of training for recertification, it is recommended that the *Family Life Plan*, be developed. Sponsoring agency staff and the Family Care provider should have a plan developed that is beneficial for both the provider and the individual(s) that plans for the future. This plan can be a rewarding experience to all. While the plan is being written for the individual, it will also prepare the provider and the family for a *new period* of his or her life.

FAMILY CARE
FAMILY LIFE PLAN

DDSO _____ Date _____

The *Family Life Plan*, to be updated every three years at the time the operating certificate is issued, by the sponsoring agency Family Care Coordinator, DDSO clinical staff or third party clinical staff.

Provider Name (last) _____ (first)_____

Address _____

Mailing Address _____

City _____ State _____ Zip Code _____

Birthdate (Optional) (____/____/____) Sex ( ) Female ( ) Male

Daytime Telephone # (____)_____ Number of Individuals Living in the Home.

1. Do any of the individuals in the home have special needs? If "Yes", please indicate below.

   _____

   _____

   _____

   _____

2. Would a family member(s) or close friends be interested in becoming a Family Care provider or respite sitter? ( ) Yes ( ) No

   a. If Yes, the family member or friend may consider attending the (10) hours of training to become an approved respite sitter/provider. He or she should know all the medical, dietary, social and emotional needs of the individual(s). He or she should know consumer advocates, nursing staff and clinical team assigned to work with the individual.

   b. Would the family member or friend be interested in caring for the individual(s) in their provider(s) home? ( ) Yes ( ) No

   c. If Yes, has the home been inspected by the DDSO? ( ) Yes ( ) No

   d. If No, to #2 above, the Family Care provider must begin making a Life Plan.

FAMILY CARE
FAMILY LIFE PLAN

3. In the event of an emergency or illness, does the provider have someone to care for the individual(s)? ( ) Yes ( ) No

4. Does the respite provider live in the home? ( ) Yes ( ) No

5. Does the provider have access to a listing of approved respite sitters/providers? ( ) Yes ( ) No

6. Does the Family Care provider plan to retire within three (3) years? ( ) Yes ( ) No

   a. If Yes, the provider may choose to participate in developing another living arrangement for the individual(s).

   b. Eight (8) weeks prior to retiring, the Medicaid Service Coordinator working in cooperation with the Family Care provider and the Family Care Home Liaison should begin introducing the individual(s) to his or her proposed new family and home:

      i. Scheduling trial visits to meet the proposed family, tour the home and the neighborhood.

      ii. Having dinner with the proposed provider and family members.

      iii. Staying over night and spending a weekend with the proposed family.

7. Does the provider have any additional recommendations to include in the *Family Life Plan?* If Yes, please comment below:

_____

_____

_____

_____

FAMILY CARE
FAMILY LIFE PLAN

DATA ON THE INDIVIDUAL

DDSO _____ Date _____

Name (last) _____ (first) _____

Address _____ State _____ Zip Code _____

DOB (_____/_____/_____) Sex ( ) Female ( ) Male

1) Medical Needs

_____
_____
_____
_____
_____
_____
_____
_____
_____

2) Dietary Needs

_____
_____
_____
_____
_____
_____

FAMILY CARE
FAMILY LIFE PLAN

3) Medication(s)

_____

_____

_____

_____

4) Special Equipment, such as wheelchair, cane, walker, hearing device, etc.

_____

_____

_____

_____

_____

_____

5) Modifications such as adaptive tub or shower, ramp.

_____

_____

_____

_____

_____

_____

6) Behavioral Concerns

_____

_____

_____

_____

_____

_____

FAMILY CARE
FAMILY LIFE PLAN

7) ADL Skills

_____
_____
_____
_____
_____
_____
_____
_____

8) Does the individual(s) attend day services outside the home? If Yes, please list the name of the program and how frequently does the individual attend.

_____
_____
_____
_____

9) How often would the individual(s) benefit from a nurse's visit? 1/month 2/month_____ More frequently, please explain.

_____
_____
_____
_____
_____
_____

10) When did the individual last visit his or her physician? Please list the physician's name.

_____

_____

_____

11) Does the DDP2 need to be revised such as the individual needs assistance with ambulation, beginning signs of dementia, soiling, enuresis, wandering at night, difficulty in swallowing, eating. If Yes, please describe.

_____

_____

_____

_____

_____

_____

_____

12) Is there any other information that will assist the provider and sponsoring agency in locating the best home for these individual(s)? If Yes, please comment.

_____

_____

_____

_____

_____

_____

_____

_____

_____

SECTION 14

RECORD KEEPING

Each provider is encouraged to keep a notebook or a three ring binder containing pertinent information received concerning the individual(s) to include copies of Residential Habilitation Plan, medication records, medical conditions/concerns, menstrual records, financial information, list of on-call staff, emergency numbers, etc. Keeping a notebook will help the provider organize papers and keep them in one place.

Providers must also maintain notes on any changing health condition of the individual to be shared with the physician, and/or nurse assigned to the home.

Each Family Care provider is responsible for managing of his or her own funds, as well as, the personal allowances of the individual. The provider must:

1. Record the date of receipt, type of income, and the amount of each check in a ledger or three ring binder.

2. Maintain receipts to accurately account for expenditures on behalf of the individual.

3. Notify the Family Care Home Liaison if monies accrue to more than what is allowed in regulations.

4. Make available all ledgers/notebooks to be reviewed by the Family Care Home Liaison on a quarterly or semiannual basis.

5. Maintain an accounting of all funds to the home, SSI, SSA, Difficulty of Care, etc. for the provider's information and tracking.

RECORD PAYMENTS FOR FAMILY CARE

Enter below the name, date, amount, and source of income received for each individual.

Individual	Date Received	Source (SSI, SSA, DOC, Clothing, Transportation, etc.)	Amount

Reviewed by:

Date Reviewed: _____/_____/_____/_____/_____/_____/

RECORD OF EXPENDITURES

Enter below the date and amount of all expenditures made on behalf of the individual. Please attach any receipts.

Individual' Name	Date	Amount	Receipt Attached Yes No

12/00

Reviewed by:

Date Reviewed: ____/____/____/____/____/____/____/____/____

SECTION 10.15

GLOSSARY

Abuse:

The maltreatment or mishandling of a person receiving services which would endanger the physical or emotional well-being of the person through the action or inaction on the part of anyone, including Family Care providers, an employee, volunteer, consultant, contractor, visitor, other people, whether or not the person is or appears to be injured or harmed. The failure to exercise one's duty to intercede in behalf of a person receiving services also constitute abuse. While a person receiving services may have allegedly abused another person receiving services, it is necessary to take into consideration the aggressor's judgment and cognitive capabilities to determine whether the act is to be reviewed as an abuse allegation or as a behavioral problem.

Active Tuberculosis:

A condition characterized by a significant reaction to the Mantoux skin test, the appearance of symptoms of tuberculosis, and with a tuberculosis organism usually found in the sputum. In order to spread tuberculosis germs, someone must have active tuberculosis disease that is still infectious.

Adaptive Behavior:

This is the results of an assessment based on a standardized instrument as appropriate to the area being assessed which indicate the individual evidences one or more characteristics such as: communication, independent living, learning, mobility, or self-direction.

Adaptive Devices:

These devices are aids, controls, appliances or supplies of either a communication or adaptive type that are necessary to enable the individual to increase or maintain his or her ability to live at home and in community with independence and safety.

Admission:

An individual may be moved directly into a Family Care home when the individual has a documented diagnosis of developmental disability and his or her needs and preferences can be met by the Family Care Program.

Advocate\Correspondent:

A person (not on the staff of an agency) chosen by the individual who assists the individual with the waiver application process and in the development, implementation, review, and revisions of the services, supports, and activities that the individual chooses in order to attain his or her personal life goals and individualized service environment (ISE). The advocate or correspondent must be 18 years or older and may include an involved parent or other member of the family, legal guardian, friend, or member of the community who is not providing direct services to the individual pursuant to the individualized service plan or who is not employed by an entity providing direct services to the individual in the waiver.

The fact that an advocate or correspondent is providing advocacy for an individual does not endow that party with any legal authority over the individual's affairs. A correspondent or advocate also receives notification of significant events in an individual's life.

Agency Sponsored Family Care (ASFC):

An oversight entity of one or more OMRDD certified Family Care homes. The homes are certified in accordance with the same regulations, guidelines and policies as the State Sponsored Program. In the case of Family Care homes under state sponsorship, the DDSO is considered to be the sponsoring agency.

Allegation of Abuse:

The implication that abuse of the individual may have occurred based upon the report of a witness, upon the individual's own account, or upon physical evidence of probable abuse.

Allowable Items:

These are particular adaptive devices that are specifically listed in the waiver agreement with HCFA.

Assault:

Based on the Penal Law in New York State, the following may be used as a guideline as to what should be reported to law enforcement authorities: any situation where there is intent to cause physical injury (impairment of physical condition or substantial pain) to another party and such injury occurs to that party or another.

Assessment:

The process, performed or supervised by an appropriately licensed or certified professional, that identifies the individual's present medical and /or developmental status including diagnosis of his or her strengths, abilities, needs, preferences and the conditions that affect the individual's development.

Assistive Technology Modifications and Devices:

These are adaptations; items or pieces of equipment that can help the individual live independently in the home of his or her choice with the maximum possible control over their activities within the Family Care home and in the community.

Assistive Technology Services:

These are services that directly assist the individual with a disability in the selection, acquisition or use of an assistive technology.

Capable Adult:

An individual 18 years or older who is able to understand the nature and implication of various issues such as person centered planning, treatment and movement. The individual in conjunction as it arises will make the assessment of capability in relation to each issue with his or her advocate, service coordinator, and the team. Capability does not mean legal competency. An individual may be capable of participating in planning for his or her services and programs but still require assistance in the management of financial or other matters. If there is doubt as to the individual's ability to make decisions, a determination of capability made by an external capability review board, designated by the commissioner. A capable adult cannot override the authority of a guardian appointed in accordance with the Surrogate's Court Procedure Act, or Article 81 of the Mental Hygiene Law.

Certified Capacity:

The maximum number of beds available in a Family Care home for individuals with developmental disabilities for residential or for respite purposes, as indicated on the operating certificate issued by OMRDD. In determining certified capacity, OMRDD will take into consideration all others residing in the home, the nature of the services needed by the

individual(s), and the ability of the provider to offer those services, in relation to using available space and accommodations. Any change in the total number of those living in the home may affect the certified capacity.

Chief Executive Officer:

Someone (by whatever name or title known) designated by the governing body with overall and ultimate responsibility for the operation of one or more sponsoring agencies, for the delivery of other services to individuals with developmental disabilities, or a designee with specific responsibilities as specified in agency policy or procedure. In the DDSO, this party is referred to as the director.

Child:

An individual under age 18.

Client Identification Number (CIN)

This is an eight-character number in the following format: AANNNNNA (A - Alpha; N-Numeric). A CIN is assigned by the State Department of Social Services for each Medicaid-eligible individual and appears on the Medicaid card. The individual's CIN must be provided to service providers to access any Medicaid-reimbursable services.

Committee on Special Education(CSE):

A team established in accordance with the provisions of Section 4402 of Article 89 of the Education Law or 8 NYCRR Section 116.6 (a) consisting of at least a school psychologist, an educator or administrator of special education, a physician, and a parent of an individual with a developmental disability who is not an employee of OMRDD. This committee is charged with the responsibility to identify, review, and evaluate any child with a developmental disability or any child thought to be disabled, with the goal of recommending an appropriate educational program or placement or the advisability of continuation, modification, or termination of a current special education program or placement. For the purposes of this policy, two types of committees on special education are defined.

1). School District - CSE - that committee established as above by the board of education or trustees of the school district in which the Family Care home is located.

2). Developmental Disabilities Services Office - CSE - that committee established as above by the DDSO director. The parent member of the committee must be a parent of an individual who is developmentally disabled. The DDSO CSE is a standing committee and is not the same as the team.

Community Education Program:

A non-residential education program operated by a local school district's Board of Education, a Board of Cooperative Educational Services, or private agency which offers a program approved by the New York State Department of Education.

Conditional Operating Certificate:

The issuance of an operating certificate that is subject to and/or restricted by such things as the circumstances that must be met before a regular operating certificate can be issued or, to make it possible for a prospective provider to avail himself or herself of a Family Care loan.

Day Habilitation Services:

These are services that enhance skills necessary to perform an activity that commonly occurs outside of the individual's home. These services help the individual achieve satisfying and rewarding connections and relationships within their communities. These services can be combined with many other activities or services, such as employment or traditional day services.

Developmental Disability:

A disability of an individual which:

1. is attributable to mental retardation, cerebral palsy, epilepsy, autism, or neurological impairment; or

2. is attributable to any other condition of an individual found to be closely related to mental retardation because the condition results in similar impairment of general intellectual functioning or adaptive behavior to that of individuals with mental

retardation or requires treatment and services similar to those required for such individuals; or

3. is attributable to dyslexia resulting from a disability described in paragraph (1) or (2) above;

4. originates before age twenty-two (22);

5. has continued or can be expected to continue indefinitely; and

6. constitutes substantial functional limitations to the individual's ability to function normally in society.

Developmental Disabilities Services Office (DDSO):

The local administrative unit, responsible to the OMRDD Central Office, that has major responsibility for planning, and developing of residential, and other program services in the community. The DDSO is responsible for coordinating the service delivery system within a particular service area, planning with community and provider agencies, and confirming that specific individual placement and program plans, and provider training programs are implemented.

Discharge:

The release of an individual from the sponsoring agency, and the termination of program, and/or services.

Discontinuance of Living Situation:

When the Family Care home closes because of an emergency, because the operator is no longer capable or interested, or the individual is no longer appropriate for Family Care, and is moved for clinical reasons, or because OMRDD revokes the Operating Certificate, and continued residence is not possible.

Early Intervention Program (EIP):

The early intervention program is for infants and toddlers (children ages birth through two).

Earned Income:

Income received as a result of work directly performed by an individual. This income includes gross wages from employment, net earnings from self-employment, and any payment received by an individual for work performed in a sheltered workshop, and/or work activity center.

Electric Benefit Transfer (EBT):

Environmental Modifications (E-Mods):

These are adaptations to the home that are necessary to increase or maintain an individual's ability to live at home with independence. These adaptations address needs related to physical, behavioral, or sensory disabilities, and help ensure that an individual's health, safety and welfare needs are met. Environmental modifications must be part of the individual's service plan.

Failure To Thrive (FTT):

This term is used to designate growth failure both as a symptom and as a syndrome. As a symptom, it occurs in persons with a variety of acute or chronic illnesses that are known to interfere with normal nutrient intake, absorption, metabolism, or secretion, or the result in greater than normal energy requirements to sustain or promote growth. In these instances it s referred to as *organic FTT.*

When the term is use to designate a syndrome, it most commonly refers to growth failure in the infant or child who suffers from environmental neglect or stimulus deprivation. It is the designated *nonorganic FTT*, indicating the absence of a physiologic disorder sufficient to account for the observed growth deficiency. The physiologic basis for impaired growth is inadequate nutrition to support weight gain.

Family Care Coordinator (FCC):

A Qualified Mental Retardation Professional (QMRP) staff member (by whatever title known) designated by the sponsoring agency as having administrative responsibility for the agency's Family Care Program.

Family Care Home:

The combination of a private residence, and a party or parties certified by OMRDD, pursuant to, and in accordance with the provisions of Article 16 of the Mental Hygiene Law, Part 687 and Section 635-7.4 of 14 New York Codes, Rules and Regulations (NYCRR), and other applicable regulations of the Commissioner, to provide care for no more than four (4) individuals with developmental disabilities (except for those homes providing Family Care for more than 6 but no more than 10 individuals on July 1, 1975).

Family Care Home Liaison (FCHL):

The staff member at the sponsoring agency (by whatever title known) with primary responsibility for ensuring that all program and any environmental requirements related to the Family Care home are being met and maintained. This staff person also ensures that fiscal, and other provider needs and concerns are addressed, and are met consistent with the needs of the individual(s) living in the home.

Family Care Program:

A residential program using private certified homes to provide care for individuals who do not require residential care and treatment in a more restrictive residential setting but who are unable to function adequately in their own homes or in independent living arrangements in the community.

Family Care Provider:

One or more adults age 21 or older to whom an operating certificate has been issued by OMRDD, through the DDSO, to operate a Family Care home. Family Care providers may be married couples, persons who are divorced, widowed, or single adults of either sex, provided all requirements for certification are met. A provider may own a home or rent or lease a house or an apartment. A Family Care provider is an independent contractor.

Fetal Alcohol Syndrome (FAS)

This is the name given to a group of physical and mental birth defects that is the direct result of a woman's drinking alcohol during pregnancy. Fetal Alcohol Syndrome (FAS) is a series of defects that can include mental retardation, growth deficiencies, central nervous dysfunction, craniofacial abnormalities and behavioral maladjustments.

Group Purchases:

The purchase of an item for the collective benefit of the contributing individuals by the pooling of personal allowance monies in accordance with Social Security requirements.

Habitable Space:

Space that is occupied by one or more persons for living, sleeping, eating or cooking.

Home Additions:

This is any increase in the square footage of a home or generally any expansion beyond the existing footprint of the home. Modifications to interior space are not considered home additions.

Home School District:

The school district, also known as the school district of origin, in which the child resided immediately prior to being placed with the Office of Mental Retardation and Developmental Disabilities or the Office of Mental Health, which is responsible for the child's educational costs.

Home and Community Based Services (HCBS) Waiver:

OMRDDs primary financing mechanism for the Individualized Service Environment (ISE). Implemented in September 1991, this federal Medicaid program supplies the financial support for thousands of people with developmental disabilities to live as integral members of the community. The HCBS waiver funds eight services: service coordination, residential habilitation (including Family Care and community residential habilitation), day habilitation, prevocational services, supported employment, respite, environmental modifications, and adaptive technology.

Human Immunodeficiency Virus (HIV):

An infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of acquired immune deficiency syndrome (AIDS).

Human Immunodeficiency Related Information:

Any information concerning whether the individual being served or being considered for admission has been the subject of an HIV related tests, or has HIV infection, HIV related illness or AIDS, or information which identifies or reasonably could identify such individual having one or more conditions, including information indicating an individual's potential exposure to HIV. This information is confidential and can only be released in accordance with law.

Inconclusive:

It is impossible to capture sufficient information that would support or disapprove an abuse allegation.

Individualized Education Program (IEP):

A statement that sets learning goals for the student, and describes the services and programs that the school district will provide.

Individualized Service Environment (ISE):

This is a service delivery system in which the individual's living arrangement and service delivery reflect the individual's personal goals; preferences and needs are not linked, with services considered discretely rather than in a package. The ISE is in distinct contrast to an overall or comprehensive residential services model, in which housing and some services are intrinsically linked (i.e., where an individual lives largely determines the services received).

Investigate/Investigation:

That systematic process whereby information about the circumstances surrounding an event and/or situation are examined, and scrutinized, whether by a chief executive officer,

designated staff, or a trained investigator. The intensity of any "investigation" is decided by the event and/ or the situation under study.

Individualized Service Plan (ISP):

A personal life plan or blueprint that summarizes the help an individual who has developmental disabilities wants and needs to achieve his or her own aspirations in life. These aspirations or personal goals are known as the person's valued outcomes. The goal of the ISP is to ensure the provision of those things necessary to sustain the individual in his or her chosen environment. These services, activities and supports, identified in the ISP, are to reflect the preferences and capabilities of the individual, and emphasize the development of self-determination (i.e., making personal choices), independence, productivity, and integration into the community.

Medicaid:

A needs based program that pays enrolled providers for Medicaid goods and services provided to eligible aged, blind or disabled individuals. Applicants must have limited countable income and resources to qualify and meet other non-financial eligibility criteria.

Medicaid Service Coordinator (MSC):

A person who is chosen by, and is accountable to, the individual to help him or her explore what they want and need in life, and then assist them in obtaining it. The Medicaid Service Coordinator works in partnership with the individual, or family to promote informed choices, to develop, implement, and maintain the person's life plan.

Medicare:

A federal health insurance coverage program for individuals 65 and older, disabled insured workers or some disabled dependents/survivors of insured workers.

Mental Hygiene Legal Services (MHLS):

An agency of the appellate division of the State Supreme Court, established pursuant to Article 47 of the Mental Hygiene Law, to provide protective legal services, advice, and assistance to individuals with developmental disabilities.

Natural Parent:

The biological mother or father of a child.

Natural Supports:

This is a term for what an individual finds in the community. Families, friends, neighbors, and community organizations are "natural supports." They are called natural because they exist in the community for everyone and are not just there because the individual has developmental disabilities.

Non-Correspondent or Advocate Status:

When there is no advocate or correspondent acting on behalf of an individual as established by an annual determination. Additionally, for a Willowbrook Class Member, non advocate or non correspondent status means that the advocate or correspondent has failed to respond to a notice of proposed placement or that the advocate or correspondent has indicated that he or she does not wish to participate in placement planning. The Consumer Advisory Board (CAB) of the Willowbrook Class represents members of the Willowbrook Class who are considered to be on non-advocate or non-correspondent status.

Office of Mental Retardation and Developmental Disabilities (OMRDD):

The administrative and regulatory state agency responsible for the design, authorization, development, operation, and certification of services, programs, and facilities providing care to individuals with developmental disabilities in New York State.

Operating Certificate:

A written document, valid for up to three years, issued by OMRDD giving authorization for a Family Care provider to operate a Family Care home at a specific address.

Parent

A parent by birth or adoption, or person in parental relation to the child. With respect to a child who is a ward of the state, or a child who is not a ward of the state but whose parents by birth or adoption are unknown or unavailable and the child ha no person in parental

relation, the term "parent" means a person who is appointed as a surrogate parent for the child in accordance with Section 69-4.16 of Part 69 of Title 10. This term does not include the state if the child is a ward of the state.

Person Centered Approach:

This approach seeks to build on the individual's abilities and skills rather than concentrating on deficiencies. Every planning effort and decision is made from the perspective of the individual for whom the plan is being developed. The intent is to meet that individual's outcome rather than those of others.

Personal Allowance:

That portion of income which is made available on a monthly basis to an individual residing in a Family Care home. The amount is determined regardless of the source of income, by using the current amount stated in Section 131-o of the New York State Social Services Law, and all income exemptions provided for in current regulations governing Supplemental Security Income (SSI), Medicaid eligibility and payment. Personal Allowance may have several components, depending on individual circumstances.

Personal Expenditure Plan (PEP)

Personal Outcome:

A destination, a desired end or result, such as: living in a safe home and with a trusted friend, enjoying the garden and backyard more often, learning how to stand up for himself or herself, being comfortable and without pain, learning how to check-up on a provider, learning self-protection, having opportunities to be around people who are not disabled.

Placement:

The relocating of an individual from the community, from an OMRDD sponsored and/or certified residential facility to another residential setting as proposed, and planned by the individual, and/or his or her advocate, and the service coordinator or relocating of the individual to an OMRDD operated or certified residential facility as requested by a capable adult or someone acting on the individual's behalf.

Preliminary Individualized Service Plan (PISP):

This is part of the enrollment process for the Home and Community Based Services Waiver that gives a "first cut" view of the individual and of his or her needs and wants. The PISP is valid for sixty (60) days.

Recreation Trips:

Trips that, though beneficial to the individual, are not typically identified in the Individualized Service Plan, but may be documented in the individual's record. Examples of such trips may include vacations where an individual accompanies the Family Care provider, or overnight trips to participate in recreational and/or social activities.

Reportable Incidents:

Significant events or situations endangering an individual's well being which are required to be recorded on standardized Form OMR 147 Reportable Incidents, and/or reviewed, investigated, and reported to designated parties according to established procedures of the sponsoring agency. The review is conducted by a standing committee, and acted upon in an appropriate manner by the program administrator. A serious incident must be immediately reported to OMR and followed up in writing on Form OMR 147 (1).

Representative Payee:

The person or organization designated by the Social Security Administration to receive benefits on behalf of a beneficiary.

Residential Habilitation Services:

These are the activities and supports an individual receives, usually in the home but sometimes in the community as well, which may help the individual achieve his or her personal valued outcomes that appear in the Individualized Service Plan.

Respite:

An indirect short-term "substitute service" that provides relief to individuals who are responsible for the primary care and support of individuals. When a Family Care provider has to deal with such things as illness, emergency, death or vacation, respite services are

intended to ensure that the individual (s) will continue to receive the care he or she needs. Respite services, provided hourly or over night, can be provided in the home of the individual or in the home of an approved respite sitter or in another community residential setting approved by the DDSO.

Respite Bed:

A bed in a Family Care home documented for "respite" by being designated on the operating certificate as being available for such use. A "respite bed" cannot be used for permanent occupancy.

Self-Administration of Medication:

The self-directed act of taking the right medication at the right time, in the right dosage and manner. This includes the ability: to recognize the time when medication is to be taken; to identify the container; to open the correct container; to remove the correct dosage, and to close the container; to obtain appropriate fluids or materials needed to ingest, apply, inject, or otherwise use as ordered; and to return medication to the appropriate storage area.

1. **Independent Self-Administration of Medication** - To consistently self-administer medication. Supervision and/or assistance is needed in exceptional circumstances only.

2. **Self-Administration of Medication with Supervision** - To self-administer medication with occasional verbal prompting and/or training and/or monitoring.

3. **Self-Administration of Medication with Assistance** - To self-administer medication with frequent or regular verbal prompting, and/or instructions/training, and/or frequent or regular physical aid.

Sexual Contact:

As specified in Penal Law 130.00(3), the touching or fondling of the sexual or other intimate parts of an individual not married to the actor for the purpose of gratifying the sexual desire of either party, whether directly or through clothing. It also includes causing the individual to touch anyone else for the purpose of arousing or gratifying personal sexual desires.

Social Security:

An income insurance program for covered workers and some of their dependents and survivors when the worker becomes unable to work because of disability, retirement or death.

Sponsoring Agency:

The oversight entity of a Family Care Program. In the case of Family Care homes sponsored by OMRDD, the DDSO is considered to be the "sponsoring agency." Certified Family Care providers are not considered to be an "agency."

Standards of Certification:

Those criteria that specify the basis for documenting compliance for the purposes of issuing an operating certificate. The basis of documentation may include sponsoring agency specific record; specified forms or reports; specified contents of records, reports, or forms and/or other means of assessing compliance such as interviews with individuals receiving services at the sponsoring agency, employees, volunteers, and/or on site observation of activities and the environment.

Supplemental Security Income:

A needs based program that provides or supplements income to an eligible aged, blind or disabled individual. Payments will vary depending on the individual's living arrangement.

Surrogate Parent:

A person who is appointed in accordance with Section 200.5(e) of 8 New York Codes, Rules and Regulations (NYCRR) in the absence of participation by the child's parent or guardian, for the limited purpose of assisting the child to obtain necessary educational and related services, and assisting the Committee on Special Education in the educational planning process.

Suspected Tuberculosis Disease:

A condition whereby someone exhibits the clinical symptoms of active pulmonary tuberculosis or a condition whereby someone has a significant reaction to the Mantoux skin test, a suspicious or positive chest x-ray, who may or may not have clinical symptoms of tuberculosis, and is waiting for confirmation as to whether or not tuberculosis organisms are present in the sputum.

Team:

Members of a group of persons acting as a unit who will assist the individual in making informed decisions, based upon the individual's needs, choices, and preferences, and not upon a predefined program.

Therapeutic Leave:

The period of time when an individual is temporarily absent from a Family Care home for a period of twenty-four (24) hours or more for programmatic, recreational, social, or health\medical reasons which are not programmatically contraindicated.

Training:

The dissemination of information to Family Care providers, employees, volunteers, or individual receiving services by any appropriate method, and which is documented to have taken place. Training may include, but is not limited to, orientation (formal or informal), instruction sessions (formal or informal), self-instruction, on-site instruction, formal training or educational activities at a DDSO/Sponsoring agency or elsewhere, and field trips.

Trial Visit:

A brief or overnight stay at a certified Family Care home which is intended to provide a period of orientation or transition for an individual prior to permanently moving into the home.

Tuberculosis:

A bacterial disease usually affecting the lungs (pulmonary tuberculosis). Other parts of the body can also be affected, for example, lymph nodes, kidneys, bones, joints, etc., (extra pulmonary tuberculosis).

Unearned Income:

Any income not defined as earned income, including the following:

1. Pensions and other benefits (e.g., Social Security Benefits, Veterans Benefits, Civil Service Annuities, Railroad Retirement Annuities, Workers' Compensation Benefits);

2. Support and maintenance (e.g., child support, in kind support such as clothing, food, etc.);

3. Inheritances and gifts;

4. Life insurance proceeds;

5. Rents, interests, dividends, and royalties;

6. Prizes and awards; and

7. Alimony.

Verify:

Any means including, but not limited to, observation, interview, and the written word that provides OMRDD with a basis for being reasonably assured that a requirement has been met.

Willowbrook Class Members:

All individuals who had been admitted to Willowbrook Developmental Center, and who were on resident leave status as of March 17, 1972.

Willowbrook Permanent Injunction:

A court order, agreed to on March 11, 1993, that replaced the Willowbrook Consent Judgment or Decree in New York State Association for Retarded Citizens (NYSARC), and Parisi v. Carey. Plaintiffs and OMRDD agreed to guarantee class members certain basic enumerated rights, and sets standards for community residential, and treatment services, service coordination, and advocacy services, and the representation of non-correspondent class members by the Consumer Advisory Board (CAB).