

REVISED 03/29/07

# **THE KEY:**

**THE HOME AND COMMUNITY-BASED  
SERVICES PROVIDER GUIDE**

**WITH**

**APPENDIX D  
CONTAINING THE MOST CURRENT  
ADMINISTRATIVE MEMORANDA**

**REVISED 12/1/06**

**THE KEY TO INDIVIDUALIZED SERVICES  
THE HOME AND COMMUNITY  
BASED SERVICES WAIVER**

**A PROVIDER GUIDE – OMRDD**

**A PUBLICATION OF THE  
NEW YORK STATE  
OFFICE OF MENTAL RETARDATION  
AND  
DEVELOPMENTAL DISABILITIES  
1997**

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# ACKNOWLEDGMENTS

The 1997 edition of the Provider Guide to the Home and Community Based Services waiver was produced by the efforts of many people. Our gratitude extends to more people than can reasonably be cited in this limited space. To everyone who made time to offer suggestions, our sincere thanks for your help. A few shouldered much of the burden to write, review, and produce this edition. Special thanks go to...

DDSO staff who reviewed the draft chapters and forwarded comments from numerous people in the field. The insights of state and voluntary agency providers gave an infusion of practicality to the theoretical constructs of the Individualized Service Environment. Although comments typically came from directors, we appreciate their ghost writers.

Our editorial board with parents and non-OMRDD staff who gave a reality check to the content as well as assurances the message would be user friendly. The members of that group include: Gary Bagnato, Dave Borge, Richard Bosch, Kathy Broderick, Nancy Cannon, Ann Hardiman, Steve Holmes, Linda Kelly, and Honey Leone. The contribution of any others they contacted is also appreciated, although they remain anonymous.

The Central Office Leadership Team, for their guidance. Philip Catchpole deserves an acknowledgment for his timely support and guidance.

Our managing editor. Doug Allen pulled together extremely diverse strands of information and produced a text that is understandable to consumers, families, and service providers. William Bird was an editor "friend indeed" to us during the final stages, and we thank him.

Deborah Sturm Rausch and Stephen Benya, who produced the graphics. We appreciate their support.

Finally, a core of central office staff, who repeatedly gave their time to ensure that the factual material was up-to-date and presented in a cohesive style. They include Thomas Articola, Suzanne Benson, Joan Burkard, Esther Callaghan, Jonathan Clement, Robert Davies, Elizabeth Essien, Harvey Gingold, Susan Grasso, Eugenia (Jenny) Haneman, Cathy Karp, Judith Kleinberg, Cathy LeFevre, Doris Mallory, Kate Marley, Cheryl Mugno, Michael Muller, Thomas O'Brien, Kevin O'Dell, Denise Pensky, David Picker, Jhansi Ravipati, and Linda Reinhardt.

Many thanks to all...

Max Chmura  
Director  
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## PREFACE

This Provider Guide is intended to orient the reader to the current administrative requirements of the Home and Community Based Services waiver. It also shows how the HCBS waiver supports the Individualized Service Environment and Person Centered approaches to service delivery and planning. Taken together, these elements are the foundation of current efforts to transform the OMRDD and voluntary agency network of programs.

The chapters provide definitions, instructions, and insights that are essential for using HCBS services to respond to the needs of a person who has developmental disabilities. The material focuses on the consumer first, as the ISE does, and highlights administrative or policy issues that have either undergone or are expected to undergo significant change. This will help the reader understand and perhaps anticipate the continuing evolution of this administrative tool.

This Provider Guide will not answer all questions. Often it refers to other related documents that will be useful, or it anticipates the use of professional judgment or best practices. Also, because it is written for a broad audience, details applicable to a narrow segment of experience may not be included. Finally, many questions have not yet been raised and therefore have not been answered. That is the challenge of operating in an evolving environment.

The bottom line is that this Provider Guide offers a key to helping people who have developmental disabilities. It will help people access supports and services available through the HCBS waiver, and this in turn will make the Individualized Service Environment a reality.

# **Chapter 1 - INTRODUCTION**

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New York State's Individualized Service Environment (ISE) is a doorway to successful living in the community for people who have developmental disabilities. The ISE allows the design of uniquely tailored packages of supports and services that help each person pursue his or her goals in life. A person's independence and inclusion in the community are primary concerns in designing these packages, as is the productive use of personal time. The Office of Mental Retardation and Developmental Disabilities (OMRDD) has developed the ISE over the past ten years in collaboration with consumers, families, and providers, to the point where the ISE now has become the major strategic force that is transforming New York's services. The system formerly dominated by congregate care programs now is changing to a flexible resource network that offers a balance between traditional "model-based" programs and individualized services.

The Home and Community Based Services (HCBS) waiver has been OMRDD's primary financing mechanism for the Individualized Service Environment. Implemented in September 1991, this federal Medicaid program provided the financial catalyst for OMRDD's system transformation. It has been the key to the doorway to successful living in the community. Tens of thousands of people have moved from segregated congregate care facilities to live as an integral part of the community thanks in great measure to the supports and services funded through the HCBS waiver.

Even as the importance of the HCBS waiver is discussed and debated, it should be noted that the waiver is one funding mechanism supporting the Individualized Service Environment. OMRDD has other means of supporting the ISE as well. However, since it is the primary funding mechanism, administrative decisions made for the HCBS waiver often have broad influence in OMRDD's system.

The agency has learned much from the first five years of practical experience. However, the HCBS waiver is in transition. And it is not just the waiver that is undergoing changes. As the twenty-first century approaches, emerging philosophic, programmatic, and fiscal forces are transforming the entire array of resources available to people who have developmental disabilities. As this occurs, OMRDD expects that the funding available through the changing HCBS waiver will continue to make appropriate supports and services available for increasing numbers of people. The waiver – or its successor – will remain the key that unlocks the doorway to more successful living in the community.

Since the 1970s OMRDD has been working to restructure a system that previously housed people with developmental disabilities in large institutions. Enlightened and motivated by consumer advocacy, federal legislation, and court decisions, OMRDD worked hand in hand with not-for-profit providers to move thousands of people into the community. These efforts were so successful that, by the state fiscal year 1997-1998, twelve of the original twenty developmental centers in New York will be closed. During this time New York also expanded its community system dramatically. A wide variety of services now are provided to over 95,000 people through the network of programs sustained by OMRDD and the not-for-profit sector.

The redirection and growth of the 70s and 80s were accomplished using program models like the Intermediate Care Facility for the Mentally Retarded (ICF/MR) and the Community Residence, along with complementary day programs like Day Treatment and Sheltered Workshops. Using those and other program models that were supported by successive legislative budgets, New York State was able to sustain dramatic growth in services.

Toward the late 1980s OMRDD began to look beyond these residential and program models. They required placing people out of their own homes, and were in some respects still segregated from the community. Responding to consumers and a changing service philosophy on the national scene, OMRDD began to look toward supporting families and individuals in their own homes and communities. This change in outlook was based on the fact that the more support people received in their own homes, the more control they gained over their own lives. As consumers and families had more say in these matters, they declared that what they wanted often differed from what was available. And often it differed from what others thought they should have in the form of supports and services.

Early efforts to help persons living at home – through the Family Support Services and Individual Support Services programs – reinforced these conclusions. Using experience as a catalyst, OMRDD, working with consumers and providers, began to rethink the future of services for people who had developmental disabilities.

During the 1990s, OMRDD and the provider community have been focusing the future of our service system on the personal choices and needs of those among us who have developmental disabilities. Progress may be seen in broadening efforts to help people live in homes they choose, including homes they rent or own. Progress is also manifest in burgeoning efforts to help people get jobs or do more than just visit the community -- to help them accomplish things that are productive and valued. Letting people decide what supports and services are most appropriate for their personal goals is a highlight of this new focus. And this emphasis on choice applies to all consumers, at all levels of our system, including those who are still benefitting from traditional program models.

In September 1991, OMRDD implemented the Home and Community Based Services waiver. New York State chose this administrative tool to provide predictable Medicaid financing for supports and services received in homes and community settings. It was the tool of preference because it provided management flexibility and stable funding -- both of which were needed to establish the Individualized Service Environment. In fact, since 1991 this Medicaid waiver program has funded fully 85% of the expansion in supports and services within the ISE, and the HCBS waiver has been the key to achievement in the lives of thousands of enrolled individuals.

## **Status of the HCBS Waiver**

The HCBS waiver is currently in its first five-year renewal period. New York has federal authority to operate the waiver through August 1999, with additional renewal periods available thereafter. Although Medicaid reform is under discussion on the national level, Medicaid funding for the services now available through the HCBS waiver will survive any Executive or Congressional decisions.

Twenty-seven thousand people are enrolled in the HCBS waiver as of November 1996. One out of four lives at home, either with his or her family, or in a home that he or she rents or owns. One out of five people lives in a family care home. The remaining individuals live in certified residences operated by voluntary agencies or OMRDD. The ages of the people enrolled in the HCBS waiver run from preschool (1.1%) to over 80 years old (1.3%), with most people in the 30 to 40 year age range. A disproportionately high number have severe disabilities when compared to all people in the system. In the same ratio as found in the rest of the OMRDD system, 56% are male, and 44% are female. The HCBS supports received most frequently are service coordination and residential habilitation. Recently, more people have been accessing day habilitation, supportive employment, respite and environmental modifications.

## **The HCBS Waiver in Transition**

The waiver has undergone tremendous change since it was first approved. When implemented, the HCBS waiver targeted only four geographic regions of New York State. It was also expected to serve only 6,500 people during its first three years. However, by 1992, OMRDD had approval to open the doorway to people throughout the state. By 1993 OMRDD had received federal authority to serve more than 24,000 people in the waiver. That number has risen again. Now the federal government has granted New York State the authority to serve up to 31,655 people by September 1999, a target which will be reached and possibly exceeded. With this rapid growth have come tremendous currents of change, not the least of which has been retooling OMRDD's administrative structure to accommodate lessons of experience.

How people use the HCBS waiver has also changed as the MRDD field in general and OMRDD in particular have embraced consumer empowerment and inclusion. The past two years have seen significant increases in the number of people enrolled in the HCBS waiver and living at home or in family care. People are deciding that it is better to request services that enable them to live in settings more integrated with the community than to live in certified residences operated by either the state or voluntary agencies. As OMRDD has increased its emphasis on person centered approaches to service planning and delivery, more and more support packages are being tailored to individual needs and desires than are typically offered in program models.



## Chapter 2 - INDIVIDUAL ENROLLMENT

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## Requesting Services – The Basics Before Enrollment

A person who has a developmental disability and lives in New York State can request services funded by OMRDD in a variety of ways. The person and his or her family can: 1) call OMRDD directly, 2) ask a local government agency to assist them in accessing OMRDD funded services, or 3) have a not-for-profit agency make such a request on their behalf.

This request can begin with something as simple as a telephone call or it can begin with an office visit where forms are completed. With the individual's or family's agreement, it can also be integrated into a service funding proposal submitted by an agency which has been selected to deliver the support or service.

OMRDD's interest is in making it as easy as possible for the person to begin a dialogue about what supports or services he or she is seeking, and whether or not they can be provided through OMRDD funding.

Any such request will be reviewed by staff in one of OMRDD's Developmental Disabilities Services Offices (DDSOs) or the New York City Regional Office (NYCRO). Regardless of the type of support or service requested, or individual eligibility, each request will be considered within the framework of the DDSO/NYCRO funding decisions related to the Community Services Plan (CSP). This CSP review process applies to all requests for OMRDD services – for HCBS waiver services as well as all other services. (See "Funding for Waiver Services," Chapter 13.)

All decisions to authorize funding for requested supports or services will be based on the three main criteria used in the CSP process:

- Verification of a formal diagnosis of developmental disability (see page 2-4).
- Matching the needs presented by the individual with established priorities for funding.
- Determination that sufficient funding is available to pay for any agreed upon supports or services.

Final decisions about enrolling any person in the HCBS waiver are based on the Community Services Plan process. Specifically requesting HCBS enrollment as part of the initial request provides no advantage with regard to the three basic criteria used in CSP funding decisions. Once a decision has been made that the individual requesting services will or should submit an application for enrollment in the HCBS waiver, a number of procedural tasks and steps are triggered.

## Enrollment in the HCBS Waiver

In order to receive waiver services, an individual must be enrolled in the HCBS waiver. The Developmental Disabilities Services Office (DDSO) must approve each individual for enrollment, and for this to occur, *three basic criteria must be met: the individual must be eligible, he or she must meet any priority categories established through an OMRDD sanctioned local planning process, and OMRDD funding for his or her supports and services must be available.*

### DDSO authorization is based upon evidence of:

- Developmental disability
- Eligibility for ICF/MR level of care
- Medicaid enrollment
- Local priorities
- Availability of requested services and funding
- Appropriate living arrangement
- Choice of HCBS waiver services in preference to care in an ICF/MR

### Seven Steps to Enrollment

1. Individual decides to apply for HCBS services.
2. Individual completes HCBS application packet.
3. DDSO reviews packet for completeness.
4. DDSO reviews Preliminary Individualized Service Plan.
5. DDSO assesses priorities and availability of funding.
6. DDSO documents individual's choice of HCBS services.
7. DDSO issues a Notice of Decision.

## 1 - Individual Decides to Apply for HCBS Waiver Step 1 to Enrollment

A consumer who has a developmental disability may seek access to any OMRDD funded supports or services including home and community based services. The decision to *participate in the HCBS waiver* or access other supports is an individual's choice. Some consumers will make this decision by themselves. Others will decide with the assistance of an interested party--a family member, friend, legal guardian, member of the community, or other person who has a significant relationship with the consumer.

Once an individual informs the DDSO that he or she wants to apply for the HCBS waiver, a formal Medicaid time frame takes effect. DDSO staff should record this date on the Application for Participation (HCBS Form 02.01.97) form as the "Date of stated intent to apply for HCBS waiver services." This means that *the DDSO has 90 days from that point to make a decision and issue a Notice of Decision.* (HCBS Forms 02.05.97; 02.06.97 and 02.07.97) The DDSO is expected to make decisions well before the 90 days are up unless there is difficulty gathering the necessary information from the consumer or the people assisting him or her.

90 days from Application to Notice of Decision
---------------------------------------------------

If the individual wishes to select a service coordinator at this time, see Chapter 6 of this guide.

## 2 - Individual Completes HCBS Application Packet Step 2 to Enrollment

The individual and those assisting him or her to apply for the HCBS waiver are responsible for completing certain elements of this packet. Those elements include: the Application For Participation, the Preliminary Individualized Service Plan (PISP) (HCBS Form 02.04.97), and the Documentation of Choices form (HCBS Form 02.03.97). The identity of the chosen advocate is indicated on the signature line of this last form.

The other elements (ICF/MR Level of Care Eligibility and Documentation of Medicaid Eligibility) will be completed by the DDSO or other designated parties. However, the individual and those assisting him or her have a responsibility to make sure that all elements are completed and submitted to the DDSO in a timely fashion. *The DDSO cannot begin its formal review of this application until that is done although the 90 day time limit is in effect.*

Since the DDSO has only 90 days to make a decision from the point in time that they were notified that the individual wishes to receive HCBS services, the DDSO also needs to ensure that the Level of Care determination and Medicaid eligibility verification are completed in a timely manner.

## **DDSO Reviews Request for Service and Verifies Developmental Disability Diagnosis**

In order to receive any services from OMRDD a person must have a formal diagnosis of mental retardation or other developmental disability. *The onset of this disability must have been manifested prior to age twenty-two.* The verification should be assured at the time the person presents himself or herself to OMRDD to minimize unnecessary paperwork for the consumer. If the person has a developmental disability, this is documented on the ICF/MR Level of Care Eligibility Determination Form (HCBS Form 02.02.97) as described below.

### **Documentation of ICF/MR Level of Care Eligibility**

#### *What is required?*

An ICF/MR Level of Care Eligibility Determination Form *must be completed within 30 days* of the date the DDSO receives the person's signed Application for Participation. This allows the final decision to be made within the time frames specified above. This evaluation will be completed by a qualified staff person using a process and criteria explained in instructions to the form (see page 2-14).

#### *Who is qualified to do the evaluation?*

To be qualified to make this evaluation, staff must have a minimum of one year of experience in the performance of assessments and development of plans of care for persons with developmental disabilities.

#### *Who is authorized to complete the form?*

The DDSO will decide whether DDSO staff complete the level of care form, or whether staff from other specified agencies will be given this authorization.

#### *Are people with alternate care determinations eligible?*

An individual who is determined by a second step review to be on Alternate Care Determination (ACD) *status is not eligible for waiver services*. However, if there is clinical documentation that the person's condition has significantly changed since the ACD, a new level of care determination (for waiver eligibility) may be considered. Clearly, this is an action that should occur infrequently, on an exception basis, and with written clinical justification.

### **Documentation of Medicaid Eligibility**

#### *What is required?*

To participate in the waiver, an individual must be enrolled in the Medical Assistance (Medicaid) program. This is indicated by inclusion of the person's Medicaid Identification Number on the application form. The DDSO will verify this enrollment.

## *How would someone enroll in Medicaid?*

Persons who are not enrolled in Medicaid complete the following steps:

1. The DDSO informs the OMRDD Revenue Support Field Office (RSFO) staff that the consumer must file for Medicaid (MA) with the Social Services District Office.

The DDSO should ensure that the individual meets all conditions for waiver enrollment (except MA eligibility) prior to sending him or her to the Social Services District Office.

2. The RSFO staff gives the applicant a referral letter to present to the Social Services District Office. The RSFO staff will also contact the Social Services District Office and make arrangements for a Medicaid appointment for the applicant and interested parties, if appropriate.
3. The Medicaid eligibility process will be performed pursuant to the most advantageous method available to the family, but please **NOTE** the following special provision.

Regarding children under the age of 18 who are living at home, or who are expected to live outside the parental home for less than 30 days in one of the appropriate HCBS waiver living arrangements: their Medicaid eligibility will be determined by disregarding parental income and resources and applying only the child's income and resources.

4. After a determination has been made by the Social Services District regarding Medicaid eligibility, the Social Services District Office will send a copy of the Notice of Decision on Your Medical Assistance Application to the RSFO. *The RSFO will then contact the DDSO advising them of this decision.*

**Note:** For persons enrolling in Medicaid as part of the HCBS application process, the effective date for HCBS enrollment should be the same as the effective date for Medicaid enrollment.

### **Individual's Advocacy Choice**

OMRDD assumes that all people with developmental disabilities have some capacity for self-advocacy and decision making. This is one of the fundamental values of the Individualized Service Environment (ISE). In addition, OMRDD assumes that some people with disabilities are capable of self-advocacy in the service planning process. If a person indicates that he or she is capable of self-advocacy in the service planning process, the DDSO will validate this in accordance with 14 NYCRR 633.99 (person, capable adult). If the applicant has an advocate, this person is identified at this point in the enrollment process. *Those not capable of self-advocacy must have an advocate.* The identity of the chosen advocate should be indicated in the signature block on the Documentation of Choices form (HCBS Form 02.03.97). See Chapter 3 for detailed information about **Advocacy**.

## **Preliminary Individualized Service Plan (PISP)**

Consumers, as part of the application process, must tell OMRDD what supports and services they believe they need, and why. The “why” should explain briefly how the requested supports and services will help the individual achieve desired valued outcomes and pursue his or her personal goals.

The Preliminary Individualized Service Plan is a plan that briefly identifies the applicant's personal goals related to the Individualized Service Environment, and the supports, services, and activities the applicant proposes to select in pursuit of those goals. There must be a general “fit” between the consumer's personal goals, preferences, interests, needs, and capabilities and the identified activities, supports, and services that could make up his or her ISE. To the extent that unusual safeguards or protections are related to an individual, they should be included as well. The intent is to indicate that natural supports, Medicaid State Plan Services, HCBS waiver services, and other services are used appropriately, in a reasonable and proper balance. The PISP should minimally provide a description of the services that will need DDSO funding. Step 4 explains how the DDSO reviews the PISP (see page 2-7).

The level of detail required in a PISP is less than the level that will be required of the final Individualized Service Plan. The PISP is a brief, “first cut” description of the person and what he or she wants. Service coordinators, with the consumer and advocate, will use the PISP as a starting point to develop a comprehensive Individualized Service Plan. The Health Care Financing Administration (HCFA) accepts the abbreviated PISP format to substantiate billing for the first 60 days of service delivery, after which a comprehensive ISP is required.

The applicant and his/her advocate must be afforded the opportunity to make informed decisions in the development of the preliminary plan. The service coordinator will build on this process for the development of the Individualized Service Plan. **If possible, the chosen service coordinator should participate in the development of the preliminary service plan.**

### **Assurance of Informed Choice**

Informed choice is a fundamental and critical part of the HCBS waiver application process. The Documentation of Choices form, with appropriate signatures, assures that informed choices were made.

## **3 - DDSO Reviews Packet for Completeness Step 3 to Enrollment**

The HCBS Application Packet, when completed, will contain all the information and documentation necessary for OMRDD to determine whether or not a person can be enrolled in the HCBS waiver.

**Record Maintenance** - The documentation described in this section will be maintained by the service coordinator in the person's record, along with the ISP. A copy will be maintained at the DDSO.

**Required Elements of Application:**

Documentation of ICF/MR Level of  
Care Eligibility

“Application for Participation” Form

Documentation of Medicaid Eligibility

Indications of Individual’s Choice of Self-advocacy or Identification of the Advocate  
Chosen

“Documentation of Choices” Form

Preliminary Individualized Service Plan

**4 - DDSO Reviews Preliminary Individualized Service Plan  
Step 4 to Enrollment**

DDSO review of the PISP focuses on the following issues:

1. Identification of the consumer's personal goals or desires.
2. Assessment of the individual and/or his or her requested supports or services against established priorities (see Special Note on “Impact of Priorities on Enrollment”).
3. Verification that the services requested meet the HCBS definition.
4. Determination of those services that must be funded by the HCBS waiver and those that may be provided through other resources. This will involve a review of any natural supports, community resources, Medicaid state plan services, federal or state agency funded services, HCBS waiver services, and other services that should be used in a reasonable and proper balance. (This may just consist of a confirmation of the review completed as part of the CSP process.)
5. Verification that at the time of enrollment the individual resides either *at home, in a certified family care home, community residence, or Individualized Residential Alternative (IRA)*. As a rule, waiver services cannot be provided until the individual is actually living in one of the above situations. On a limited basis, exceptions may be granted for service coordination and environmental modifications services when the applicant lives in an ICF/MR, skilled nursing facility (SNF), or hospital. This does not preclude accepting an application from a person who is still residing in an ICF, SNF, or hospital, but participation in the waiver program cannot begin until the individual is discharged from institutional care.

## **5 - DDSO Confirms Price of HCBS Service and Sets Effective Date Step 5 to Enrollment**

As part of the CSP process, the projected cost of needed supports and services has been established – including any HCBS services. At this point in the HCBS enrollment process the DDSO will finalize the price(s) of any involved HCBS service and set an effective date for the person’s enrollment. The effective date is often tied to when the funding will be available to support the agreed upon support or service.

## **6 - DDSO Documents Individual's Choice of HCBS Services Step 6 to Enrollment**

When the DDSO has determined that all other enrollment criteria have been satisfactorily met, the DDSO will confirm that the individual applying for enrollment and his/her advocate have been informed of the alternatives available under the waiver, and of the choice between an ICF/MR or HCBS waiver services. The individual's choice will be documented by completing Section A of the Documentation of Choices form.

This form must be signed prior to completion of a Notice of Decision.

In those cases where someone other than DDSO staff assisted the applicant, the DDSO signature confirms the understanding of DDSO staff that the applicant was adequately informed of available choices.

## **7 - DDSO Issues a Notice of Decision Step 7 to Enrollment**

When all of the above steps have been taken, the DDSO informs the individual of approval or denial of the application by issuing a Notice of Decision within 90 days on behalf of the “single State Medicaid agency.” *The Notice of Decision will also advise the individual with disabilities and the advocate of the right to request a Medicaid Fair Hearing.*

If the application is approved, the Notice of Decision is sent to the individual, with copies to the parties listed on the form. Please note that a copy is sent to the involved local Social Services District Office which has fiscal responsibility for the individual. **If this office is not in the county where the individual resides, an additional copy must also be sent to the Social Services District Office in the individual's county of residence.**

At times it will be necessary for a DDSO to deny the application for enrollment in the HCBS waiver. This decision should be made only by the Director after the consumer or their advocate are offered an opportunity to discuss the reasons for the possible denial and supply any additional supporting information that may cause the DDSO to rethink its position. At the time that the Director makes the decision to deny enrollment, a Notice of Decision will be issued which indicates the reason(s) for denial. It will identify to the consumer the reason for denial and that he or she has the right to request a conference and/or a Medicaid Fair Hearing on this denial.

*At this point the enrollment process is completed.*

## Termination of Individual Enrollment

Once enrolled in the HCBS waiver it is *very unlikely* that an individual will be terminated from the waiver unless he or she so chooses. Should termination become a possibility the following procedures apply.

The *service coordinator* is responsible for initiating the process of terminating the enrollment of a participant in HCBS waiver services by notifying the DDSO when any of the following occurs:

- The individual chooses not to receive the services any longer.
- The individual is no longer eligible for HCBS waiver services because he or she is no longer eligible for Medicaid.
- The individual is permanently admitted to an Intermediate Care Facility (including developmental centers, community-based ICFs, and Small Residential Units [SRUs]) a specialty hospital, a skilled nursing facility, or a psychiatric center.

When the DDSO Director approves the termination of enrollment, the DDSO will issue the Notice of Decision which identifies the reasons for termination and advises the individual and advocate of the right to request a Medicaid Fair Hearing. The notice will be sent to:

- Individual (unless death is the reason for termination).
- Advocate.
- Service Coordinator (Case Manager).
- DDSO staff who input data into **TABS**.
- Providers of waiver services to that individual.
- Bureau of Community Funding, 30 Russell Road, Albany, NY 12206.
- Social Services District which has fiscal responsibility.
- Social Services District Office in the county of residence must also be notified when that county is different from the county which bears fiscal responsibility for the individual.

The Notice of Decision – HCBS Waiver Termination must be mailed at least 10 days prior to the effective date of termination. If the individual requests a fair hearing and “aid continuing” prior to the effective date of termination, State DSS will determine whether the individual is entitled to have his or her current services continue unchanged pending a fair hearing decision. DDSOs should consult with Counsel’s Office prior to terminating services in such cases.

Once termination of services occurs, three things should happen: providers should cease delivering waiver services to the individual, no bills should be submitted to Medicaid for services delivered after the termination date, and the individual's name should be deleted from administrative rolls in order to free up that waiver opportunity for someone else. (Local Social Services district staff will “end date” the HCBS waiver code in the Welfare

The DDSO staff must ensure that the date of termination is noted in TABS. If the reason for termination of services is Medicaid ineligibility, then the termination date will be the date indicated on the Notice of Intent to Discontinue Medical Assistance issued by LDSS. In all other cases, *the termination date will be the date service delivery ends.*

If a person transfers from one DDSO to another, and plans to continue HCBS waiver services, it is not necessary to terminate enrollment. Staff at the involved DDSOs, however, must make the necessary changes in TABS to reflect the transfer. They should also notify the appropriate Social Services District of the move.

### **Suspension of HCBS Services v. Termination**

Any of the circumstances listed at the beginning of the above section could lead to termination from the waiver. *However, termination is not required if* the individual is expected to return to HCBS services within a reasonable period of time. For instance, if he or she is no longer eligible for the HCBS waiver because Medicaid eligibility has lapsed due to time limited income, and the person expects to be re-enrolled in Medicaid in a short while, termination is not required. **Termination of the delivery and billing of HCBS services** is required, but the person can remain administratively enrolled in the HCBS waiver.

This “suspension of HCBS services” allows individuals to avoid lengthy re-enrollment proceedings. If the absence from the waiver was due to changes in eligibility status, then the individual must document that the required eligibility criteria have been met (re-enrollment in Medicaid, for the example above).

There is a time limit that must be used in any “suspension of HCBS services.” OMRDD has decided that, without cause, the suspension of HCBS services cannot exceed 75 days. If, at the end of 75 days, the individual and service coordinator cannot demonstrate to the DDSO’s satisfaction that the individual will return to the waiver shortly, the DDSO should issue a Notice of Decision – HCBS Waiver Termination form. If the DDSO agrees to extend the enrollment beyond this 75 day limit, such extensions should be in writing and reviewed every 30 days thereafter.

### **Enrollment and Due Process Rights**

Certain HCBS related actions of the DDSO require that the individual be notified of his or her rights to a Fair Hearing under Medicaid. Those actions include:

1. **Authorization of Enrollment**
2. **Denial of Application**
3. **Termination of HCBS Enrollment**

Should any of the above actions occur, the DDSO must issue the appropriate Notice of Decision which includes language notifying the individual that he or she has the right to request a Medicaid Fair Hearing. A Medicaid Fair Hearing is requested through the NYS

Department of Social Services. Individuals who will be terminated from HCBS are entitled to continue receiving current waiver services, also known as “aid continuing,” if they request a Fair Hearing prior to the effective date indicated on the Notice of Decision. In such cases HCBS waiver services continue unchanged until the hearing is withdrawn or a final decision is issued. The Notices of Decision include the appropriate language as well as information on how to contact the appropriate offices. Additional information about due process rights may be found in the Chapter 7, “Individualized Service Plan.” Decision forms are located at the DDSO office.

## **Special Notes**

### **Timely Information and Feedback**

DDSOs must create time lines for decision making and create regular communication links with consumers and families to inform them of the status of their requests or applications. DDSO staff are responsible for responding promptly to individual requests for information, within two or three business days in non-emergency cases. The DDSO will identify a contact person for questions regarding the status of enrollment applications.

### **Enrollment in Other Medicaid Waivers**

Individuals may not be enrolled in, or receive services from, more than one Medicaid waiver at a time.

### **Individual's Choice of Service Coordinator**

Each individual enrolled in the HCBS waiver must select a service coordinator from a list of authorized service coordination organizations available in his or her community. The selection is made by the consumer and his/her advocate and may be made either:

- a. During the application process; or,
- b. At the point in time when the Notice of Decision is issued, notifying the person that the application is approved.

### **It is the responsibility of the DDSO to:**

Ensure the selection of a service coordinator.

Ensure that the consumer and advocate were given information about currently available and geographically accessible service coordination options, including DDSO and authorized not-for-profit providers. This information must be provided in a manner that affords the individual and his/her advocate the opportunity to make an informed and reasonable choice.

Ensure that the consumer and advocate have been informed that they may select a different service coordinator should they become dissatisfied.

Provide the consumer and advocate with information regarding the responsibilities of a service coordinator.

## **Application Date and Enrollment Date**

The application date is the “date of stated intent to apply for HCBS waiver services” on the Application for Participation form (see Step 2). The enrollment date is the effective date of the individual's participation in the waiver as indicated on the Notice of Decision.

## **Initial Funding**

HCBS waiver funding comes out of a DDSO's Community Service Plan Allocation including operations and capital, or through reinvestment of funds in the budget base.

## **TABS Registration**

For each application that is approved, the DDSO ensures that the individual is properly registered in TABS. The RSFO also ensures that the local social services district is informed of all new enrollments, changes, or terminations. (See Special Note below on LDSS Change of Status forms.) This must be done for all participants receiving services from a state or voluntary waiver service provider.

## **Record Maintenance**

The documentation described in this section will be maintained by the service coordinator as part of the ISP and a copy will be maintained at the DDSO.

## **EASy Application Process**

OMRDD has developed and is testing a streamlined process for consumer applications to all funded services, including the HCBS waiver. Once available, EASy (Electronic Application System) will include, and slightly modify, the Documentation of Choices form.

## **Impact of Priorities on Enrollment**

The approved HCBS waiver application is an agreement between the State of New York and the Health Care Financing Administration on, among other things, the number of eligible people who can be enrolled in the waiver during any given year. That number is associated with the funding levels available in the state through the annual budget appropriation.

Given that restriction, OMRDD has created a Community Services Plan process which requires annual funding priorities to be established. These funding priorities reflect any targeted populations identified in the Legislative Budget as well as others whose needs are most consistent with the agency's overall goals of maintaining family unity, preventing out-of-home placements, reuniting families, maximizing potential, and integrating individuals in their communities.

Using centrally established guidelines, DDSOs are required to establish local priorities and internal procedures for reviewing requests for services, evaluating applications for services and reevaluating the need for continued supportive services. These priorities and procedures must be made available to the public and described to individuals who request HCBS waiver services.

## **Willowbrook Class**

Once enrolled in the HCBS waiver, members of the Willowbrook Class are entitled to specific considerations as required by litigation. Consumers, families, and staff should refer to *The Willowbrook Permanent Injunction* for a definitive explanation of entitlements.

## **LDSS Change of Status Forms**

The Change in Status forms (HCBS Forms 02.08.97 and 02.09.97) are used to notify Local Department of Social Services (LDSS) offices when a person enrolled in the Home and Community Based Services waiver moves to a new LDSS district, or a person moves to a different type of residence within the same LDSS district. The purpose of this form is to alert LDSS offices that a coding change is necessary in the Welfare Management System (WMS). These codes must be updated to ensure that Medicaid claims for waiver services are paid promptly and that the information contained in WMS is reliable.

The Change of District version of the form (HCBS Form 02.08.97) is used when someone moves from the jurisdiction of one Social Services District to the jurisdiction of another (a change in county of residence). The DDSO completes the form and sends it to the new LDSS district, along with a copy of the original Notice of Decision form. A contact at the local RSFO office should be indicated on the form so that the new Social Services District knows who to call if there are any questions.

The Change Within District version of the form (HCBS Form 02.09.97) is used when there is a change in living arrangement within district (e.g. moved from home to a CR). The person's new address must be listed, the appropriate box is checked to indicate the new living arrangement, and the effective date of the change is recorded.

The change of status forms are to be used only when there is a permanent move from one county to another or one type of residence to another within a county. They should not be completed when someone moves on a temporary basis, for example from family care to an IRA for emergency respite.

## Forms

Application for Participation (HCBS Form 02.01.97)	1 Page
ICF/MR Level of Care Eligibility Determination Form (URAC-2 [4-86]) (HCBS Form 02.02.97)	1 Page
Form Instructions	10 Pages
Documentation of Choices (HCBS Form 02.03.97)	1 Page
Preliminary Individualized Service Plan (HCBS Form 02.04.97)	2 Pages
Notice of Decision	
HCBS Waiver Authorization (HCBS Form 02.05.97)	4 Pages
Denial of Application (HCBS Form 02.06.97)	3 Pages
HCBS Waiver Termination (HCBS Form 02.07.97)	3 Pages
Change in Status (Change of District) (HCBS Form 02.08.97)	1 Page
Change in Status (Changes Within District) (HCBS Form 02.09.97)	1 Page

**Copies of the HCBS enrollment forms listed above are included in the following pages of this chapter.**

APPLICATION FOR PARTICIPATION IN THE  
OMRDD HOME AND COMMUNITY BASED SERVICES WAIVER

Name of Applicant: \_\_\_\_\_

Current Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ County: \_\_\_\_\_

Check here if not currently enrolled in Medicaid.

I am requesting participation in the Home and Community Based Services Waiver administered by the New York State Office of Mental Retardation and Developmental Disabilities. I understand that approval will be based on my choice of Home and Community based services in preference to care in an Intermediate Care Facility for the Mentally Retarded and on evidence of:

- developmental disability;
- eligibility for admission to an Intermediate Care Facility for the Mentally Retarded;
- eligibility for Medicaid enrollment;
- availability of appropriate community based services; and
- appropriate living arrangement

Date of stated intent to apply for HCBS waiver services: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Applicant Name (Print): \_\_\_\_\_

Assisted by (Signature): \_\_\_\_\_

Assisted by (Print): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Date: \_\_\_\_\_







## **Instructions for Completion of the ICF/MR Level of Care Eligibility Form (URAC-2) (4-86) for HCBS Waiver**

The following information packet is meant to provide staff with assistance in completing the ICF/MR Level of Care Eligibility Determination (LCED) form. This form is used for the initial determination and annual re-determination of a person's eligibility to receive HCBS waiver services. This packet includes the criteria for determining eligibility, as well as step by step instructions for completing the form. The criteria are the same for the initial and annual reviews. They are not to be confused with the Independent Utilization Review criteria for people residing in ICF/MR.

The form for the level of care determination is completed by the UR Coordinator, the designated QMRP, a person assigned by the DDSO, or a qualified person at the voluntary agency who is familiar with the needs of the person applying for the waiver. To be qualified to make this evaluation, staff must have a minimum of one year's experience in the performance of assessments and development of plans of care for persons with developmental disabilities. The initial evaluation must be completed within 30 days of the date the DDSO receives the person's signed Application for Participation (or prior to admission and the initiation of services for a person moving to a community residence).

The completed level of care determination form is signed by the qualified person in the area on the form where it asks for the "Signature of UR Coordinator." A physician and the DDSO director or designee must then review the initial level of care eligibility determination and sign the form where indicated.

The Second Step Review is not applicable and should not be completed. **Leave this section blank.**

The annual re-determination must be completed one year from the anniversary date (date of DDSO director's or designee's signature or the signature of the supervisor of the qualified person completing the form) of the previous determination of a person's eligibility for ICF/MR level of care. For the annual re-determination, the supervisor of the person completing the level of care may sign in place of the DDSO director. The annual re-determination may be signed by a physician's assistant or nurse practitioner if so authorized by a physician.

If the initial or annual re-determination of level of care results in a negative determination, refer to the procedures outlined on the back of the Denial of Application form or the HCBS Waiver Termination form, as appropriate.

The original of the initial level of care form as well as each annual re-determination form should be maintained in the person's case record with a copy forwarded to the DDSO Quality Assurance office.

## Determination of Eligibility

**A person is determined eligible for ICF/MR Level of Care for HCBS waiver services if:**

There is documentation of one or more of the diagnosis listed under Question 1,

AND

Question 2 is checked "YES."

AND

A "YES" is checked in either

Question 3

(Check "YES" if the person's record indicates that the person exhibits antisocial behavior which endangers himself or others.)

OR

Question 4

(Check "YES" if any of the listed conditions (A, B, or C) are evident from the person's record or from observations of the person.)

OR

Question 5

(Check "YES" if adaptive behavior deficits are indicated in any of the listed areas.)

## Identifying Information

Facility Name/Address: Address where person will be residing while receiving HCBS waiver services

Persons Name: Individual's first and last name

DOB: Date of Birth (numeric)

Status: Indicate if individual is 620 or 621 eligible

Social security Number: Complete

Person's Medicaid Number: Complete

Responsible County: County which has fiscal responsibility for the person.\*

Provider Number: List the residence operating certificate number if presently living in a CR or IRA

MMIS Number: Complete

### Dates of Pre-enrollment Evaluations:

**Medical:** Current (completed within the last year) physical exam completed by a physician, registered physician's assistant or nurse practitioner.

**Social:** Current evaluation or update completed by service coordinator or social worker.

**Psychological:** Current evaluation is **not** needed if there is sufficient information in the person's record to complete the diagnosis and adaptive behavior deficit/learning portions of the LCED form. A current evaluation (full assessment or update) must be carried out by a psychologist if the person completing and/or approving the LCED form finds that there is not sufficient psychological information to complete the form.

### Annual Level of Care Re-Determination Evaluations:

The purpose of the annual LCED is to ascertain if the person continues to meet ICF/MR level of care eligibility criteria. It is unlikely that there will be significant changes to a person's disability and level of functioning over a year's time. Therefore the person completing the LCED redetermination should be able to assess the development status of that person based on knowledge of the person and a review of the record. If additional information is needed to make a determination, updates to the medical examination, social evaluation, or psychological

evaluation may be needed. Updates may consist of notations and signatures on evaluations verifying the current status of the person.

NOTE: Part 633 requires that for people living in an OMRDD certified residential facility (IRA, CR, Family Care) a physician, registered physician's assistant, or nurse practitioner must annually evaluate the person's need for a medical examination or specific medical services.

**Note:** The dates for the pre-enrollment evaluations need only be indicated on the form for the initial determination. However, all assessments should be reviewed prior to the annual re-determination.

\* If DDSO staff are uncertain of the county which has fiscal responsibility for the person, the staff at the local Revenue Management Field Office (RMFO) should be contacted for assistance.

## Individual Eligibility Information

In the **Identification Information** section of the eligibility form, it is apparent that medical, psychological and social evaluations are necessary for determining a person's eligibility. However, the reviewer should also examine other portions of a person's record containing information which would assist him/her in determining a person's eligibility as well as information that would allow him/her to gain a composite picture of the person. The DDP score should be used as an additional source and should be reviewed to see it is consistent with other level of care information available to the reviewer. The qualified individual completing the Level of Care Eligibility Redetermination form should use the following to assist him/her in determining a person's eligibility: his/her clinical knowledge of the individual; discussions with the individual and/or advocate; notes associated with the waiver services provided; and any updated or new evaluations.

1. Diagnosis: Circle all that apply. There must be documentation that a physician has made or approved each diagnosis. In the case of a person who also has an MH diagnosis, the person's primary diagnosis (that which is dominant in terms of affecting the person's level of functioning) must include one or more listed characteristics under A-E at the time of the LCED determination.

A developmental disability is a disability of a person which is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, or autism; is attributable to any other condition of a person 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 persons with mental retardation or requires treatment and services similar to those required for such persons; is attributable to dyslexia resulting from a disability described above; originates before such person attains age 22; has continued or can be expected to continue indefinitely; and constitutes a substantial handicap to such person's ability to function normally in society.

2. Disability Manifested Prior to Age 22: Circle "YES" or "NO."

Check "YES" if the person's impairment has been documented as having occurred prior to age 22 (e.g., through medical records showing a diagnosis of MR/DD, within a school record, within the social history indicating developmental milestones, or through records documenting admission prior to age 22 to any program certified or operated by OMRDD).

Check "NO" if there is no documentation indicating that the impairment originated prior to the person reaching age 22.

OR

There is documentation that the impairment originated after the person reached age 22.

### 3. Severe Behavior Problem:

Check "YES" if the person's record indicates that the person exhibits antisocial behavior(s) which makes the individual a danger to himself or others. If "YES" is checked, complete the frequency indicator.

Examples include but are not limited to:

- A. Self-destructive behavior (e.g. attempted suicide) or other behaviors which actively threaten the life of the individual.
- B. Aggressive or assaultive behaviors that threaten the safety of other persons and which might result in criminal prosecution.
- C. Severe property damage which result in criminal prosecution.

NOTE: Incidents which occurred more than one year ago should be evaluated in terms of severity, likelihood of reoccurrence and from the perspective of the person's overall functioning level.

Check "NO" if the above does not apply.

### 4. Health Care Need:

Check "YES" if any of the listed conditions (A, B, or C) are evident from the person's record or from observations of the person.

#### A. Medical Condition:

The person requires daily individualized care by health care staff (staff trained in observing and monitoring health care needs) to address a medical condition.

#### B. Self Injurious Behavior:

The person demonstrates self-injurious behavior(s) which resulted in or will result in a condition that will require attention by health care staff.

#### C. Health Related Skill Deficit

The person demonstrates a deficit in health care skills which are identified in a clinical evaluation. The results of the evaluation should indicate that the person has deficits as described below:

- 1) The person has no self-care skills (staff must provide total care in performing self-care tasks).

OR

## Individual Eligibility Information (cont.)

- 2) The person has some self-care skills but needs assistance and or training in carrying out self-care skills.

Check "NO" if there is no evidence of a health care need.

### 5. Adaptive Behavior Deficit:

Check "YES" if any adaptive behavior deficits are indicated in areas A-E below. If A-E are all checked "NO," check "No" for this question.

#### A. Communication

Check "YES" if (1) or (2) is checked "YES"

1. Check "YES" if the individual has some expressive or receptive communication skills.
2. Check "YES" if the individual has some expressive or receptive communication skills, but needs staff assistance and/or training to communicate self-care needs.

#### B. Learning

Check "YES" for this deficit area if (1), (2), (3), (4) or (5) are checked "YES."

1. Check "YES" if I.Q. cannot be determined and there is a statement certifying that the individual is untestable.

OR

2. Check "YES" if the individual evidences an I.Q. of less than 50 or is untestable (as certified by a qualified psychologist) on an individually administered standardized instrument assessing cognitive functioning and demonstrates no pre-academic skills.

OR

3. Check "YES" if, for persons over 21 years of age, their reading and computational skills are at the first grade level or below as documented by a standardized instrument.

OR

## Individual Eligibility Information (cont.)

4. Check "YES" if the person evidences an I.Q. of 50-69 on an individually administered standardized test of intellectual functioning which has been administered by or under the supervision of a qualified psychologist.

OR

5. Check "YES" if, for persons over 21 years of age, their reading and computational skills are at the third grade level or below as documented by a standardized instrument.

### C. Mobility

This refers to basic ambulation, with or without adaptive equipment.

Check "YES" for this deficit area if (1) or (2) is checked "YES."

Check "YES" in either (1) or (2) if evident.

### D. Capacity for Independent Living

Check "YES" for this deficit area if (1) or (2) are checked "YES."

1. Check "YES" if the person is completely dependent on others for all household activities.
2. Check "YES" if the person needs assistance and/or training to perform tasks that would enable him or her to be a participating member of a household (e.g. using the telephone, using cooking appliances and utensils, using laundry equipment).

### E. Self-Direction

Check "YES" for this deficit area if (1), (2), (3) or (4) are checked "YES."

1. Check "YES" if the person demonstrates a lack of internal control and direction in his or her interpersonal or individual behavior as evidenced by weekly or more frequent exhibition of the following inappropriate behaviors requiring individualized programming:
  - a) Actively resists supervision
  - b) Temper tantrums
  - c) Verbally abusive to others
  - d) Wandering, roaming or running away

## Individual Eligibility Information (cont.)

- e) Inappropriately handles/plays with bodily wastes
  - f) Eats non-food substances
  - g) Ritualistic or perseverative behaviors which interfere with social relationships
  - h) Other behavior inappropriate to social situations
2. Check "YES" if the person is completely dependent on others for management of his or her personal affairs within the general community.
  3. Check "YES" if the person demonstrates a lack of internal control and direction in his or her interpersonal or individual behavior as evidenced by monthly or more frequent exhibition of any of the inappropriate behaviors requiring individualized programming (see a-g listed in question (1) of this section).
  4. Check "YES" if the person needs assistance or training for management of his or her personal affairs within the general community.

## **Authorizations and Signatures**

### ICF/MR Level of Care recommended:

Check this box if the person meets the eligibility criteria and if he/she is being recommended for ICF/MR level of care. The recommendation should be for a one year period. The begin date for a new enrollee should be prior to admission for a person moving to a CR or within 14 days of the waiver application date for those at home or moving to family care or an IRA. The begin date for re-determination should be prior to the expiration date (date of the DDSO director's or designee's signature, or the signature of the supervisor of the qualified person completing the form) of the previous level of care determination.

### ICF/MR Level of Care not recommended:

Check this box if the person does not meet the eligibility criteria or is not recommended for ICF/MR Level of Care.

### Date of Admission:

Indicate Waiver enrollment date if known.

### Signature of UR Coordinator and Review Date:

The level of care eligibility determination and re-determination forms are completed, signed and dated by the qualified person completing them.

### Signature of Review by Physician and Review Date:

Review by a physician is required only for the initial eligibility determination. For the annual re-determination, the review may be completed, signed and dated by a physician's assistant or nurse practitioner if so authorized by a physician.

### Second Step Review:

This section (bordered with double lines) is not applicable and should not be completed.

### ICF/MR Level of Care Approved or Not Approved:

For the initial determination, the DDSO director or his/her designee must indicate his/her approval/nonapproval for the initial determination and must sign and date the form. For the annual re-determination, the supervisor of the person completing the initial level of care determination may sign and date the form.

## DOCUMENTATION OF CHOICES

A) *SELECTION OF HCBS WAIVER:*

I \_\_\_\_\_ (applicant), have been informed that I am eligible for care provided through either an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Home and Community Based Services (HCBS). My choice is indicated below.

\_\_\_\_\_ I have chosen HCBS      \_\_\_\_\_ I have not chosen HCBS

B) *SELECTION OF SERVICE COORDINATOR:*

Service coordinator\* selected:

Name: \_\_\_\_\_

Provider Agency: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

\* An approved service coordinator is one who meets Waiver Service Coordinator qualifications.

C) *ASSURANCE OF INFORMED CHOICE:*

\_\_\_\_\_ (Service Coordinator), has informed me of all the available options\*\* with regard to service provider(s), including service coordination services.

\*\* Applicant has the right to exercise changes in choice at any time.

D) *SIGNATURES:*

\_\_\_\_\_  
(Applicant Signature/Date)

\_\_\_\_\_  
(Service Coordinator Signature/Date)

\_\_\_\_\_  
(Advocate Signature/Date)

\_\_\_\_\_  
(DDSO Representative Signature/Date)



HCBS WAIVER  
**PRELIMINARY INDIVIDUALIZED SERVICE PLAN**  
(First 60 Days of Waiver Enrollment)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Individual Profile:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Appropriate Living Arrangement (Family Care, Own Home, IRA, Community Residence)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Briefly describe each activity, support or service. Include name and type of provider, frequency, duration and effective date.**

Natural Supports (Friends, Family, Neighbors)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Community Resources (Community Associations/ Centers/Organizations, Churches, Schools, Volunteer Services, Senior Citizens Centers)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicaid State Plan Services (See Medicaid State Plan Services below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Federal or State Agency Funded Resources (VESID, State Office for the Aging, HUD, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicaid State Plan Services: Audiological, Clinic, Day Treatment, Dental, Durable Medical Equipment, Home Health Care, Hospital, Laboratory, Occupational Therapy, Personal Care, Pharmacy, Physical Therapy, Physician, Transportation, Other.

HCBS WAIVER  
**PRELIMINARY INDIVIDUALIZED SERVICE PLAN**  
(First 60 Days of Waiver Enrollment)  
(continued...)

Waiver Services Requested (See Waiver Services below)

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Other Services or OMRDD Supports

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SIGNATURES:

Waiver Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Advocate: \_\_\_\_\_ Date: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_  
(If Available)

PISP Author\*: \_\_\_\_\_ Date: \_\_\_\_\_



Waiver Services: Service Coordination, Residential Habilitation, Day Habilitation, Prevocational Services, Supported Employment, Residential Respite, Hourly Respite, Environmental Modifications, Adaptive Devices.

\*: If PISP is completed by someone other than the Consumer's Service Coordinator, that person should sign and date this form.



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.  
Commissioner

Dennis P. Whalen  
Executive Deputy Commissioner

## NOTICE OF DECISION

OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (OMRDD)  
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

### HCBS WAIVER AUTHORIZATION

Date: \_\_\_\_\_

Dear: \_\_\_\_\_

This is to inform you that your application to participate in the Office of Mental Retardation and Developmental Disabilities (OMRDD) Home and Community Based Services (HCBS) waiver has been approved effective \_\_\_\_\_.

- [ ] If you also applied for Medicaid while applying for the HCBS waiver, you have already or will be receiving a notice regarding Medicaid eligibility under separate cover. This notice will be sent by the social service district where you applied.
- [ ] You already have Medicaid coverage, and HCBS waiver enrollment will not change your Medicaid Eligibility.

Sincerely,

\_\_\_\_\_  
OMRDD Signature

\_\_\_\_\_  
Brian J. Wing  
Deputy Commissioner  
Office of Medicaid Management

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

- cc: Advocate  
Service Coordinator  
DDSO Waiver Tabs Data Entry  
VOLUNTARY AGENCIES ONLY: Bureau of Community Funding  
Local Social Services District Office (district with fiscal responsibility)  
LDSS Office in County of Residence (if different from district above)  
Bureau of Waiver Management – denials only  
Revenue Support Field Office (RSFO)

**PLEASE BE SURE TO READ THE BACK OF THIS NOTICE**



Applicant Name (Last, First, M.I.): \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Type of Current Residence (check one):

ICF       DC       CR       Own Home       Family Care       Other \_\_\_\_\_

SSN: \_\_\_\_\_

**EXPECTED** District of MA Fiscal Responsibility (check one)

TABS#: \_\_\_\_\_

County \_\_\_\_\_

CIN#: \_\_\_\_\_

State – District 98

CASE#: \_\_\_\_\_

Chapter 621 Eligible:  Yes  No

Type of ISE Residence (check one)

ISE Address (if known)

IRA

\_\_\_\_\_

Family Care

\_\_\_\_\_

Own Home

\_\_\_\_\_

Community Residence

\_\_\_\_\_

**MA RESTRICTION/EXCEPTION CODES**

DDSO staff check appropriate boxes.  
Local DSS staff data enter appropriate exception code(s) in WMS.  
EFFECTIVE DATES OF CODES – DATE OF ENROLLMENT IN WAIVER

**HCBS WAIVER CODES**

- 46      HCBS Waiver participants living in IRAs, FC, or At Home.
- 47      HCBS Waiver participants living in CRs and eligible for Sub Chapter A Day Treatment funding. \*
- 48      HCBS Waiver participants living in CRs.

\* Individuals in day treatment are eligible for Sub Chapter A funding if they are not Chapter 621 eligible, and if they are not in Family Care.



**NOTICE OF DECISION  
OMRDD HCBS WAIVER HEARING INFORMATION**

If you think this decision is wrong, you can appeal. You can appeal two ways. You can do both of the following:

1. Ask for a meeting (conference) with the Office of Mental Retardation and Developmental Disabilities (OMRDD) Developmental Disabilities Services Office (DDSO).
2. Ask for a State fair hearing with a State hearing officer from the New York State Office of Temporary and Disability Assistance (NYS OTDA).

CONFERENCE (Informal meeting with OMRDD)

If you think this decision was wrong or if you do not understand this decision, please call your local DDSO (see the phone list on page 4) to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. You are encouraged to do this even when you have asked for a fair hearing.

STATE FAIR HEARINGS

How to request a Fair Hearing

You can ask for a fair hearing by telephone or in writing.

CALL: 1-800-342-3334

OR WRITE: Send a completed copy of this notice (all pages) to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance (NYS OTDA), P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

OR GO ON LINE : <https://www.otda.state.ny.us/oah/forms.asp>

I want a fair hearing. I do not agree with the decision. (You may explain why you disagree below, but you do not have to include a written explanation.)

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Waiver Applicant's Name: \_\_\_\_\_ Address: \_\_\_\_\_

---



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Date: \_\_\_\_\_ Client Identification Number (CIN): \_\_\_\_\_

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**



**NOTICE OF DECISION  
OMRDD HCBS WAIVER HEARING INFORMATION**

**What to Expect at a Fair Hearing**

The State will send you a notice which tells you when and where the fair hearing will be held.

At the hearing, you will have a chance to explain why you think the decision is wrong. You can bring a lawyer, a relative, or a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why the decision is wrong and a chance to give the hearing officer written papers which explain why the decision is wrong.

To help you explain at the hearing why you think the decision is wrong, you should bring any witnesses who can help you. You should also bring any papers you have that you think may help you. At the hearing, you and your lawyer or other representatives can ask questions of witnesses which may help your case.

**LEGAL ASSISTANCE**

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS**

To help you get ready for the hearing, you have a right to look at your files. If you call or write to the OMRDD DDSO, they will provide you with free copies of the documents from your file which will be given to the hearing officer at the fair hearing. Also, if you call or write to the OMRDD DDSO, they will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing.

If you want copies of documents from your file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION**

If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call your local DDSO. Telephone numbers are listed below:

Bernard Fineson DDSO	(718) 217-6179
Brooklyn DDSO	(718) 642-8629
Broome DDSO	(607) 770-0211
Capital District DDSO	(518) 370-7331
Central New York DDSO	(315) 336-2300
Finger Lakes DDSO	(585) 394-7140
Hudson Valley DDSO	(845) 947-6000
Long Island DDSO	(631) 493-1745
Metro DDSO	
Manhattan	(212) 229-3601
Bronx	(718) 430-0873
Staten Island DDSO	(718) 983-5321
Sunmount DDSO	(518) 359-3311
Taconic DDSO	(845) 877-6821; ext. 3775
Western New York DDSO	(716) 517-2000





# STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.  
*Commissioner*

Dennis P. Whalen  
*Executive Deputy Commissioner*

### NOTICE OF DECISION

OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (OMRDD)  
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

### HCBS WAIVER DENIAL

\_\_\_\_\_  
Name and Address of Participant

Client Identification Number (CIN):

\_\_\_\_\_  
Date:

Dear Applicant:

[ ] Your application for participation in the OMRDD Home and Community Based Services (HCBS) waiver has been DENIED. Your participation in the waiver has been denied for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
The law that allows us to do this is Section 1915c of the Social Security Act.

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.**

Sincerely,

\_\_\_\_\_  
OMRDD Signature

\_\_\_\_\_  
Brian J. Wing  
Deputy Commissioner  
Office of Medicaid Management

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

- cc: Advocate
- Service Coordinator
- DDSO Waiver Tabs Data Entry
- Voluntary Agencies Only: Bureau of Community Funding
- Local Social Services District Office (district with fiscal responsibility)
- LDSS Office in County of Residence (if different from district above)
- Bureau of Waiver Management – Denials Only
- Revenue Support Field Office (RSFO)

**PLEASE BE SURE TO READ THE BACK OF THIS NOTICE**



**NOTICE OF DECISION  
OMRDD HCBS WAIVER HEARING INFORMATION**

If you think this decision is wrong, you can appeal. You can appeal two ways. You can do both of the following:

1. Ask for a meeting (conference) with the Office of Mental Retardation and Developmental Disabilities (OMRDD) Developmental Disabilities Services Office (DDSO).
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I want a fair hearing. I do not agree with the decision. (You may explain why you disagree below, but you do not have to include a written explanation.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Waiver Applicant's Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Date:** \_\_\_\_\_ **Client Identification Number (CIN):** \_\_\_\_\_

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**



**NOTICE OF DECISION  
OMRDD HCBS WAIVER HEARING INFORMATION**

**What to Expect at a Fair Hearing**

The State will send you a notice which tells you when and where the fair hearing will be held.

At the hearing, you will have a chance to explain why you think the decision is wrong. You can bring a lawyer, a relative, or a friend or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

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*Commissioner*

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*Executive Deputy Commissioner*

### NOTICE OF DECISION

OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (OMRDD)  
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

### HCBS WAIVER TERMINATION

\_\_\_\_\_  
Name and Address of Participant

Client Identification Number (CIN):

\_\_\_\_\_

Date:

Dear Participant:

Your participation in the OMRDD Home and Community Based Services (HCBS) waiver has been terminated. Your participation has been terminated for the following reason(s).

You have chosen not to receive the services any longer.

You are no longer eligible for HCBS waiver services because Social Services has notified you that you are no longer eligible for Medicaid.

You have been permanently admitted to an Intermediate Care Facility (including developmental centers, community based ICFs and small residential units), a specialty hospital (for other than acute hospital stay), a skilled nursing facility, or a psychiatric center. Therefore, you are no longer eligible to receive HCBS waiver services pursuant to 14NYCRR 635-10.3(b).

Other: \_\_\_\_\_

All HCBS Waiver services will be terminated on the following date: \_\_\_\_\_

Sincerely,

\_\_\_\_\_  
OMRDD Signature

\_\_\_\_\_  
Brian J. Wing  
Deputy Commissioner  
Office of Medicaid Management

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

cc: Advocate  
Service Coordinator  
DDSO Waiver Tabs Data Entry  
Voluntary Agencies Only: Bureau of Community Funding  
Local Social Services District Office (district with fiscal responsibility)  
LDSS Office in County of Residence (if different from district above)  
Revenue Support Field Office (RSFO)

**PLEASE BE SURE TO READ THE BACK OF THIS NOTICE**



**NOTICE OF DECISION  
OMRDD HCBS WAIVER HEARING INFORMATION**

New York State Department of Health

Term. Cont.  
Page 2

If you think this decision is wrong, you can appeal. You can appeal two ways. You can do both of the following:

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I want a fair hearing. I do not agree with the decision. (You may explain why you disagree below, but you do not have to include a written explanation.)

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Waiver Applicant's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date: \_\_\_\_\_ Client Identification Number (CIN): \_\_\_\_\_

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

Keeping Your Benefits the Same

We will not change your benefits if you ask for a fair hearing about the action we are taking before the date your services are terminated as indicated on the front of this notice. If you do not want your benefits to stay the same until the decision is issued, you must tell the State when you call for a fair hearing. If you write for a fair hearing, you must check the box " I want a Fair Hearing", shown above.



**NOTICE OF DECISION  
OMRDD HCBS WAIVER HEARING INFORMATION**

New York State Department of Health

Term. cont.  
Page 3

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Sunmount DDSO	(518) 359-3311
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Western New York DDSO	(716) 517-2000











**NOTIFICACION DE DECISION  
OMRDD HCBS WAIVER  
INFORMATION PARA LA REUNION ESTATAL**

Si cree que esta decisión es mala, puede pedir una reconsideración. Puede pedir la reconsideración de dos formas. Usted puede hacer lo siguiente:

1. Pida una reunión (conferencia) con la oficina de Mental Retardation and Developmental Disabilities (OMRDD) Developmental Disabilities Services Office (DDSO).
2. Pida una junta de asuntos Estatales con el Official de Juntas Estatales del Departamento de Servicios Sociales del Estado de Nueva York.

REUNIONES ESTATALES

Cómo se solicita una reunión estatal

Puede pedir una Reunión Estatal por telefono o por escrito.

Llame: **1-800-342-3334**

O ESCRIBA: Envíe una copia completa de este aviso (todas las páginas) al Office of Administrative Hearings, New York State Department of Social Services, PO Box 1930, Albany, NY 12201. Por favor guarde una copia para usted.

Quiero una hearing. No estoy de acuerdo con la decisión. (Usted puede explicar por qué esta en desacuerdo, usando el espacio posterior, pero sepa que dar una explicación esta a su discreción.

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Nombre del solicitante:

Dirección:

Fecha: \_\_\_\_\_ Número de Identificación del Cliente (CIN): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TIENE 60 DIAS DESDE LA FECHA DE ESTE AVISO PARA SOLICITAR UNA REUNION



**NOTIFICACION DE DECISION  
OMRDD HCBS WAIVER  
INFORMATION PARA LA REUNION ESTATAL**

Que se puede esperar de una Reunión Estatal

El Estado le enviará una notificación diciendole donde y cuando se dará lugar la reunión estatal.

En la reunión, tendrá la oportunidad de explicar por qué cree que la decisión es incorrecta. Puede traer un abogado, un familiar, o un amigo, o alguien quien le pueda ayudar en esto. Si no puede asistir, puede enviar un representante. Si envía a alguien que no es un abogado en su lugar, debe de proveer a esta persona una carta que demuestre al oficial que esta persona lo representará.

En la reunión, usted y su abogado u otro representante tendrán la oportunidad de explicar por que la decisión es mala y la oportunidad de darle al oficial documentos escritos explicando por qué la decisión fue mala.

Para que explique el por que la decisión fue mala, debería de traer un testigo que le pueda ayudar. También, traiga documentos que podrían servir en su testimonio.

En la reunión, usted y su abogado o otros representantes deben hacer preguntas a los testigos que pueden asistirle.

ASISTENCIA LEGAL

Asistencia Legal: Si necesita asistencia legal, puede recibir asistencia si se comunica con el Legal Aid Society de su localidad u otros grupos de abogación legal.

ACCESO A SU EXPEDIENTE Y COPIA DE DOCUMENTOS

Para ayudarle a estar preparado a la reunión, usted tiene derecho de ver su expediente. Si llama o escribe al OMRDD DDSO, ellos le enviará una copia gratis de los documentos en su expediente los cuales serán dados al oficial en la reunión. También, si llama o escribe al OMRDD DDSO, ellos le enviarán copias gratis de otros documentos en su expedientes, que le puedan servir al a preparar su reunión estatal.

Si quiere copias de documentos en su expediente, debe de pedirlos con tiempo. Usualmente, el envío dura tres días de la fecha en que los pidio. Si su reunión es en tres días, la copia de su expediente se le entregará durante su reunión.

INFORMACION

Si quiere más información sobre su caso, cómo pedir una reunión estatal, cómo tener acceso a su expediente, o como obtener copias adicionales, favor de llame a su DDSO local. Los números de telefonos son:

Bernard Fineson DDSO	(718) 217-6179
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Hudson Valley DDSO	(845) 947-6000
Long Island DDSO	(631) 493-1745
Metro New York DDSO/NYCRO	
Manhattan	(212) 229-3601
Bronx	(718) 430-0873
Staten Island DDSO/NYCRO	(718) 983-5321
Sunmount DDSO	(518) 359-3311
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# STATE OF NEW YORK DEPARTMENT OF HEALTH

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Antonia C. Novello, M.D., M.P.H., Dr. P.H.  
Commissioner

Dennis P. Whalen  
Executive Deputy Commissioner

## AVISO DE NOTIFICACION OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (OMRDD)

### RECHAZO DE SOLICITUD

Nombre y Dirección del Solicitante del Waiver:

Número de Identificación del Cliente (CIN):

Fecha:

Estimado Solicitante:

[ ] Su solicitud para participación del Crédito de Servicios de Hogar y Comunidad OMRDD (HCBS) ha sido rechazada. Su participación ha sido negada por varias razones:

\_\_\_\_\_

\_\_\_\_\_

La ley que nos permite tomar estas decisiones esta en la Sección 1915 (c) del Acta del Seguro Social. **SI NO ESTA DE ACUERDO CON ESTA DECISION, PUEDE PEDIR UNA CONFERENCIA, UNA REUNION ESTATAL, O AMBOS. FAVOR DE LEER LA PARTE DE ATRAS PARA ENTERARSE DE COMO PUEDE SOLICITAR UNA CONFERENCIA Y/O UNA REUNION.**

Cordialmente,

\_\_\_\_\_  
Firma del OMRDD

\_\_\_\_\_  
Direccion

\_\_\_\_\_  
Telefono

\_\_\_\_\_  
Firma

Brian J. Wing  
(Imprima el Nombre)

Deputy Commissioner, Office of Medicaid Management  
Titulo del DOH

cc: Abogado  
Case Manager  
DDSO Waiver TABS Data Entry  
Para Agencias Voluntarias Solamente - Bureau of Community Funding, 30 Russell Road, Albany, NY 12206  
Revenue Support Field Office (RSFO)  
Social Services District Office (distrito con responsabilidades fiscales)  
DSS Office in County of Residence (Si es diferente a las responsabilidades del condado o el fiscal)  
Bureau of Waiver Management - solamente en caso de no ser aceptado

**POR FAVOR ASEGURESE DE LEER LA PAGINA DE ATRAS DE ESTE AVISO  
NOTIFICACION DE DECISION**



**OMRDD HCBS WAIVER  
INFORMATION PARA LA REUNION ESTATAL**

Si cree que esta desición es mala, puede pedir una reconsideración. Puede pedir la reconsideración de dos maneras. Usted puede hacer lo siguiente:

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[ ] Quiero una reunión estatal. No estoy de acuerdo con la desición. (Usted puede explicar por que esta en desacuerdo usando el espacio de abajo, pero dar una explicación es algo opcional.

Nombre del solicitante:

Dirección: \_\_\_\_\_

Fecha: \_\_\_\_\_

Número de Identificación del Cliente (CIN): \_\_\_\_\_

TIENE 60 DIAS DESDE LA FECHA DE ESTE AVISO PARA SOLICITAR UNA REUNION ESTATAL



NOTIFICACION DE DECISION  
OMRDD HCBS WAIVER  
INFORMATION PARA LA REUNION ESTATAL

Que se puede esperar de una Reunión Estatal

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Manhattan	(212) 229-3601
Bronx	(718) 430-0873
Staten Island DDSO/NYCRO	(718) 983-5321
Sunmount DDSO	(518) 359-3311
Taconic DDSO	(845) 877-6821; ext.3775
Western New York DDSO	(716) 517-2000





# STATE OF NEW YORK DEPARTMENT OF HEALTH

Coming Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.  
Commissioner

Dennis P. Whalen  
Executive Deputy Commissioner

### AVISO DE NOTIFICACION OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (OMRDD) CANCELACION DEL CREDITO HCBS

Nombre y Dirección del Solicitante del Waiver:

Número de Identificación del Cliente (CIN):

Fecha:

Estimado Solicitante:

- Su solicitud para participación del crédito de servicios de hogar y comunidad OMRDD (HCBS) ha sido cancelada. Su participación en el crédito ha sido cancelada por las siguientes razones:
- Usted ha escogido descontinuar los servicios.
- Usted ya no es elegible para los servicios del crédito HCBS por que el Seguro Social le ha notificado que ya no es elegible para recibir los servicios del Medicaid.
- Usted ha sido admitido permanentemente a una Facilidad de Cuidados Intermedios (incluyendo centros de desarrollo, bases de comunidades ICF y pequeñas unidades residenciales), un hospital especial (otra que una admisión de emergencia), una facilidad de enfermería especial, o un centro psiquiátrico. De esta manera, usted ya no puede recibir los servicios del HCBS pertinentes al 14NYCRR 635-10.3 (B).
- Otros: \_\_\_\_\_

Todos los Servicios del Credito HCBS seran cancelados a partir de: \_\_\_\_\_

Cordialmente,

\_\_\_\_\_  
Firma del OMRDD

\_\_\_\_\_  
Firma

\_\_\_\_\_  
Direccion

Brian J. Wing  
(Imprima el Nombre)

\_\_\_\_\_  
Telefono

Deputy Commissioner, Office of Medicaid Management  
Titulo del DOH

cc: Abogador  
Case Manager  
DDSO Waiver TABS Data Entry  
Para Agencias Voluntarias Solamente - Bureau of Community Funding, 30 Russell Road, Albany, NY 12206  
Revenue Support Field Office (RSFO)  
Social Services District Office (distrito cin responsabilidades fiscales)  
DSS Office in County of Residence (Si es diferente a las responsabilidades del condado o el fiscal)  
Bureau of Waiver Management - solamente en caso de no ser aceptado

**POR FAVOR ASEGURESE DE LEER LA PAGINA DE ATRAS DE ESTE AVISO**



**OMRDD HCBS WAIVER  
INFORMATION PARA LA REUNION ESTATAL**

Si cree que esta decisión es mala, puede pedir una reconsideración. Puede pedir la reconsideración en dos maneras. Usted puede hacer lo siguiente:

1. Pida una reunión con la oficina de Mental Retardation and Developmental Disabilities (OMRDD) Developmental Disabilities Services Office (DDSO).
2. Pida una junta de asuntos Estatales con el Official de Juntas Estatales del Departamento de Servicios Sociales del Estado de Nueva York.

REUNIONES ESTATALES

Cómo se solicita una reunión estatal

Puede pedir una Reunión Estatal por telefono o por escrito.

Llame: 1-800-342-3334

O ESCRIBA: Envíe una copia completa de este aviso (todas las páginas) al Office of Administrative Hearings, New York State Department of Social Services, PO Box 1930, Albany, NY 12201. Por favor guarde una copia para usted.

[ ] Quiero una reunión estatal. No estoy de acuerdo con la decisión. (Usted puede explicar por qué esta en desacuerdo usando la parte posterior, pero dar una explicación es opcional.

Nombre del solicitante: \_\_\_\_\_

Dirección: \_\_\_\_\_

Fecha: \_\_\_\_\_

Número de Identificación del Cliente (CIN): \_\_\_\_\_

TIENE 60 DIAS DESDE LA FECHA DE ESTE AVISO PARA SOLICITAR UNA REUNION ESTATAL



NOTIFICACION DE DECISION  
OMRDD HCBS WAIVER  
INFORMATION PARA LA REUNION ESTATAL

Manteniendo sus Beneficios de la Misma Forma

Nosotros no le cambiaremos sus beneficios si usted pide una reunión estatal sobre la acción que vamos a tomar antes de la fecha en la cual los servicios serán cancelados, indicado en la fecha de este aviso. Si no quiere que sus beneficios continúen de la misma forma hasta que la decisión se haga, cuando pida una reunión estatal debe decirselo al estado. Si escribe para pedir una reunión estatal, debe de marcar la caja que dice AQuiero una reunión estatal, como se indica en la parte superior.

Qué se puede esperar de una Reunión Estatal

El Estado le enviará una notificación diciendole donde y cuando se dará lugar la reunión estatal.

En la reunión, tendrá la oportunidad de explicar por qué cree que la decisión es incorrecta. Puede traer un abogado, un familiar, o un amigo, a alguien quién le pueda ayudar. Si no puede asistir, puede enviar un representante. Si envía a alguien que no es un abogado en su lugar, debe de proveer a esta persona con una carta que demuestre al oficial en la reunión estatal que esta persona lo representará.

En la unión, usted y su abogado u otro representante tendrán la oportunidad de explicar por que la decisión es mala y la oportunidad de darle al oficial documentos escritos que explican la decisión tomada fué mala.

Para que explique el por que la decisión fue mala, debería de traer un testigo que le puedan ayudar. También traiga documentos que podrían ayudarle.

En la reunión, usted y su abogado u otros representantes deben hacer preguntas a los testigos que pueden asistirle.

ASISTENCIA LEGAL

Asistencia Legal: Si necesita asistencia legal, puede recibir ayuda si se comunica con el Legal Aid Society de su localidad u otros grupos de abogación legal.

ACCESO A SU EXPEDIENTE Y COPIA DE DOCUMENTOS

Para ayudarle a estar preparado a la reunión, usted tiene derecho de ver su expediente. Si llama o escribe al OMRDD DDSO, ellos le enviarán una copia gratis de sus documentos, en su expediente los cuales serán entregados al oficial en la reunión estatal. También, si llama o escribe al OMRDD DDSO, ellos le enviarán copias gratis de otros documentos en su expediente que crea le ayudarán a preparar su reunión.

Si quiere copias de documentos en su expediente, debe de pedirlos con tiempo. Usualmente, se le serán enviados en un periodo de tres días de la fecha en que los pidió. Si su reunión es en tres días de cuando solicitó copias, su expediente de documentos se le serán entregados durante su reunión.

INFORMACION

Si quiere más información sobre su caso, como pedir una reunión estatal, como tener acceso a su ficha o como obtener copias adicionales, favor llamar a su DDSO local. Los números de telefonos son:

Bernard Fineson DDSO/NYCRO	(718) 217-6179
Brooklyn DDSO/NYCRO	(718) 642-8629
Broome DDSO	(607) 770-0211
Capital District DDSO	(518) 370-7331
Central New York DDSO	(315) 336-2300
Finger Lakes DDSO	(585) 394-7140
Hudson Valley DDSO	(845) 947-1000
Long Island DDSO	(631) 434-6095
Metro New York DDSO/NYCRO	
Manhattan	(212) 229-3601
Bronx	(718) 430-0873
Staten Island DDSO/NYCRO	(718) 983-5321
Sunmount DDSO	(518) 359-3311
Taconic DDSO	(845) 877-6821: ext 3775
Western New York DDSO	(716) 674-2000



**CHANGE IN STATUS  
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER ENROLLMENT  
(Change of District)**

**TO:** \_\_\_\_\_ **From:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Enter the address of the new Local  
Department of Social Services)

(Enter the DDSO Name, Contact person  
and Telephone #)

**To be completed by the DDSO:**

Participant Name: (Last, First, M.I.) \_\_\_\_\_

Current Address: \_\_\_\_\_  
 \_\_\_\_\_

CIN Number: \_\_\_\_\_

Case Number: \_\_\_\_\_

HCBS Waiver participant moved to the jurisdiction of a new Medicaid district effective: \_\_\_\_\_

Previous District: \_\_\_\_\_ New District: \_\_\_\_\_

- ◆ The previous Medicaid district must enter an “End Date” for the Waiver Code in the WMS Restriction/Exception Subsystem one day prior to the effective date of the change in Medicaid district.
- ◆ The new Medicaid district must enter the Waiver Code indicated below in the WMS Restriction/Exception Subsystem with a “From Date” effective the date of the Medicaid district change. (See explanation of these code on the bottom of the page.)

**NOTE: A copy of the original Home and Community Based Services Notice of Decision (NOD) is attached. For additional information contact the Revenue Support Field Office indicated below.**

Name: \_\_\_\_\_ Telephone # \_\_\_\_\_

Address: \_\_\_\_\_

**Community Residence (CR)** - A facility certified by OMRDD which provides housing, supplies, and services for people who are developmentally disabled and who, in addition to these basic requirements, need supportive interpersonal relationships, supervision, and training assistance in the activities of daily living. A supervised CR may serve up to 14 people; a supportive CR up to four people.

**Family Care Home (FC)** - The combination of a private residence and an individual or individuals certified by OMRDD to provide care for developmentally disabled persons.

**Individualized Residential Alternative (IRA)** - A subcategory of certifiable facility under the general facility classification of community residence, which provides room, board and individualized protective oversight.

**Day Treatment** - A program certified by OMRDD which provides a planned combination of diagnostic, treatment, and rehabilitative services to developmentally disabled individuals in need of a broad range of services, but who do not need intensive 24 hour care and medical supervision.

hcbs waiver codes	
<input type="checkbox"/> 46	HCBS Waiver Participants living in IRAs, FC or at Home.
<input type="checkbox"/> 47	HCBS Waiver participants living in CRS and eligible for Sub-Chapter A Day Treatment funding.
<input type="checkbox"/> 48	HCBS Waiver participants living in CRS.

CC: Advocate  
 Case Manager  
 DDSO Waiver TABS Data Entry  
 FOR VOLUNTARY AGENCIES ONLY - Bureau of Community Funding, 30 Russell Road, Albany, NY 12206-1377  
 Local District Social Services Office (District with fiscal responsibility)  
 RSFO  
 Participant



## CHANGE IN STATUS HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER ENROLLMENT (Changes Within District)

TO: \_\_\_\_\_ From: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(Enter the address of the Local Department of Social Services)

(Enter the DDSO Name, Contact person and Telephone #)

**To be completed by the DDSO:**

Participant Name: (Last, First, M.I.) \_\_\_\_\_

Current Address: \_\_\_\_\_

CIN Number: \_\_\_\_\_

Case Number: \_\_\_\_\_

This is to inform you that the following actions must be taken as a result of \_\_\_\_\_ change in address/living arrangement. (HCBS Waiver Participant Name)

The HCBS Waiver participant moved from a CR to an IRA, FC or At Home effective \_\_\_\_\_

◆ Change the HCBS Waiver Code from "47/48" to "46" (See explanation of these codes on the bottom of the page.)

The HCBS Waiver participant moved from an IRA, FC or At Home to a CR effective \_\_\_\_\_

◆ Change the HCBS Waiver code from "46" to "48" (See explanation of these codes on the bottom of the page.)

The HCBS Waiver participant moved from an IRA, FC or At Home to a CR and is eligible for Sub-Chapter A Day Treatment funding effective \_\_\_\_\_

◆ Change the HCBS Waiver code from "46" to "47" (See explanation of codes on the bottom of the page.)



**Community Residence (CR)** - A facility certified by OMRDD which provides housing, supplies, and services for people who are developmentally disabled and who, in addition to these basic requirements, need supportive interpersonal relationships, supervision, and training assistance in the activities of daily living. A supervised CR may serve up to 14 people; a supportive CR up to four people.

**Family Care Home (FC)** - The combination of a private residence and an individual or individuals certified by OMRDD to provide care for developmentally disabled persons.

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<input type="checkbox"/> 48	HCBS Waiver participants living in CRS.

CC: Advocate  
Case Manager  
DDSO Waiver TABS Data Entry  
FOR VOLUNTARY AGENCIES ONLY - Bureau of Community Funding, 30 Russell Road, Albany, NY 12206-1377  
RSFO  
Participant



# Chapter 3 - ADVOCACY

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Living at home has always been very important to C.B. His mother enjoys his company and strongly supports keeping him at home. Because C.B.'s hyperactivity requires intense supervision, outside services are essential if he is to remain at home. Through the strong advocacy of his mother, a local agency now provides residential habilitation to teach C.B. skills and assist him in behavior management. Adaptive equipment has also been provided to ensure C.B.'s safety. C.B. remains contented at home because his mother successfully advocated for those services that make this living arrangement possible.

## Who Needs an Advocate

All people with developmental disabilities have some capacity for self-advocacy and decision making. This is one of the fundamental values of the Individualized Service Environment. In addition, OMRDD assumes that many people with disabilities are capable of self-advocacy in the service planning process. If a person indicates that he or she is capable of such self-advocacy, the DDSO will validate this in accordance with the definition of *capable adult person* in 14 NYCRR 633.99.

Persons who are not capable of self-advocacy *in the service planning process* need advocates. Some who lack this capacity may already have persons or agencies responsible for being their advocate. Examples could be a parent of a minor or a person for whom *a court-appointed guardian has responsibility for program planning*. A Willowbrook Class member represented by the Consumer Advisory Board (CAB) would be another example. All other consumers who are not self-advocates or who do not have such representatives will need advocates.

## What an Advocate Does

An advocate assists a person in making decisions that affect the quality of his or her life. For example, an advocate may help a person apply for services, give advice and support, help make *informed choices*, and act on behalf of the consumer when that person is unable to do so alone. At a minimum, the advocate plays an active role in promoting self-advocacy, and in assisting the consumer with service planning, implementation, and monitoring.

The advocate does not have any legal authority over the consumer's affairs unless he or she is also the legal guardian. The advocate may assist in many decisions, but is most needed for choices affecting a person's life plans.

### Advocates Assist in:

- Making Decisions
- Developing ISP
- Changing ISP
- Getting a Job
- Finding a Home
- Setting up Finances
- Setting up Spiritual Supports
- Making Social Contacts

## Who Can Be an Advocate

An advocate should be able to help a person make informed choices and, if needed, challenge the advice of a service provider. He or she should have an *"arm's length relationship"* with any provider currently delivering a service to the consumer. Interested parties, no matter how well intentioned, will not be genuine advocates if it appears that their actions may be biased or compromised.

Possible sources for advocates include a parent, a legal guardian, a family member, a representative of the Consumer Advisory Board (for *Willowbrook Class Members*), an Ombudsperson who is appointed by the Governor to act as an advocate at each DDSO, and members of the community. Members of the community who can be advocates can include:

An Advocate Can Be a:
Parent
Guardian
Family Member
CAB Representative <small>(Willowbrook Consumers Only)</small>
DDSO Ombudsperson
Community Member

- **Friends** from their place of work or social circle, including other people with a developmental disability.
- Members of the consumer's **religious community**, including clergy.
- **Former staff** who are no longer employed by an agency that provides a service to the consumer.
- **Parents of other consumers** (or other family members) from the person's residence or work place, who wish to assist a friend of their relative.
- Members of **parent organizations**.
- **Senior companions**.
- **Students** from local colleges.
- Members of **neighborhood advisory boards**.
- Staff whose agency does **not** provide direct services to the consumer in need of an advocate.

## Advocacy Consultant Groups -- Interim Advocacy Services

Many people who have a developmental disability may not have a person in their life who wishes to act as an advocate. When that is the case, the service coordinator has the responsibility to find someone to act in this capacity. Often residential habilitation or day habilitation staff discover someone who may be able to become an advocate. These staff then should collaborate with the service coordinator to encourage the interested person to learn more about the advocate's role.

While the search continues for an individual to act as advocate for a specific person, interim advocacy services may be found through an **Advocacy Consultant Group**. Members of the consultant group are composed of a few people who have an arm's length relationship in regard to service providers. Members, either individually or jointly, are consulted by the consumer or service coordinator. This may include a review of new or revised service plans or giving the consumer advice. Service coordinators may also ask the consultant group members to assist the consumer when other major events significantly affect the consumer's quality of life.

### Possible Members of an Advocacy Consultant Group

The consultant group members should be people with an arm's length relationship from service providers. The group should select someone to function as the group leader or chairperson. The group leader would act as a single contact person for service coordinators and consumers who sought input or advice. The leader would also actively recruit new members as turnover occurs.

Members of the group may include persons such as:

- a. The **ombudsperson** (for consumers receiving state services).
- b. **Clergy**.
- c. Members of **parent groups**.
- d. **Retired staff** who no longer provide a service but wish to remain involved.
- e. **Other consumers** or members of **consumer councils** who would like to assist in advocating for others.
- f. Representatives from self advocacy groups such as the **New York State Self Advocacy Association** or an **Independent Living Center**.
- g. Anyone who has an arm's length relationship with a provider of service.

Even when an *advocacy consultant group* is used, service coordinators should continue efforts to identify an individual advocate. Any DDSO or voluntary provider who chooses the advocacy consultant group model should establish a time limit for its use. The time limit chosen is at the discretion of the agency, but a 6 to 12 month limit is recommended.

## **Paid Staff as Advocates**

Whenever a person who wants to be an advocate is employed by an agency that provides services to the consumer, he or she no longer appears to have the arm's length relationship needed to be a true advocate. However, the employee may still act as the consumer's friend and voice his or her opinion about how decisions affect the consumer's quality of life. Such an employee's opinions should be welcomed by the service coordinator and carefully considered in view of the intimate, and sometimes unique, knowledge staff possess by virtue of working daily with the consumer.

Staff employed by a provider of one of the consumer's services *may temporarily act as an advocate* if the employee's recommendations are reviewed and approved by the advocacy consultant group. If the advocate meets with the consumer's approval, a DDSO or voluntary agency may choose this option. The advocacy consultant group should establish its own standard for time limits that are acceptable for employees to act as an advocate.

Paid staff acting as temporary advocates may be chosen when the ISP is developed or reviewed. It is important to use a person centered approach when identifying people who have a significant role in the consumer's life. Temporary advocates should support the consumer's view even if it differs from the views of the employer.

## **Special Notes**

### **Advocacy Training**

A training curriculum for advocates will be available by early 1997. This curriculum will be useful for parents, family members, community members and others who accept the responsibility of becoming advocates.

### **Guardians as Advocates**

Distinct types of guardianship exist in New York State. Guardians of the property of a person with disabilities, whether appointed under Article 17-A of the Surrogate's Court Procedure Act ("17-A") or under Article 81 of the Mental Hygiene Law ("81") have no authority or responsibility for the program planning process, except to authorize the expenditure of the individual's funds for appropriate services. If individuals who have such a guardian lack the capacity to advocate for themselves, then an advocate should be sought and/or application made to the appropriate court for the appointment of a guardian of the person (as opposed to the property).

A guardian of the person appointed under "17-A" generally has the authority to participate in the program planning process and should serve as the advocate. A guardian appointed pursuant to "81" will have their powers delineated in the court order. If those powers include authority to make decisions concerning program planning, then the guardian should be considered the person's advocate. If the power to participate in the program planning process is not authorized in the court order, the person should be considered capable of being their own advocate.

The appropriate court should be petitioned for a change in guardianship status under certain circumstances, for example, when the authority of a guardian is expanded to include program planning; when the authority of a guardian is restricted because the individual has the capacity to advocate for himself or herself; or when the guardian is not acting as a good advocate or in the best interests of the consumer.

### **CAB Involvement on Behalf of Willowbrook Class Members**

The Consumer Advisory Board continues to provide necessary and appropriate representation, i.e. advocacy, on an individual basis for non-correspondent class members, as long as any class member lives.

If a Willowbrook Class member is not capable of self-advocacy, and has no correspondent, or otherwise lacks **active representation**, he or she is to be referred to the CAB. Active representation for a class member is defined as participation (with the program planning team) in planning and evaluating the individual service plan and/or visits between the advocate and the class member at least annually. Merely signing consent forms sent through the mail or receiving phone calls initiated by facility staff with no other involvement does not constitute active representation.

With the consent of a class member or his or her correspondent, the CAB may also act as co-representative, thereby assisting advocates of class members who have involved family.



# Chapter 4 - NATURAL SUPPORTS

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Robb and Peter are roommates who make a great team. Robb is weak on the left side of his body, so Peter helps him climb stairs, plus do some occasional lifting. Robb is very organized. Like clockwork he reminds Peter to get out of bed in time to catch his ride to work. They live in an apartment, and staff come in periodically to help Robb. Having his friend live with him helps Robb stay in the apartment rather than at the residence where he lived before.

## **Natural Supports in a Person Centered Environment**

*A person who has a developmental disability is a member of the community.* The Individualized Service Environment promotes as a basic value the sustenance of a meaningful, reciprocal relationship between that individual and his or her community. A second basic value promoted by the ISE is a growing level of independence for that person. Natural supports can be instrumental in bringing both of these things to pass.

Natural supports is a fancy term for what a person 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 person has developmental disabilities. In fact, natural supports can greatly enrich the life of a person with developmental disabilities, offering connections to the community that strengthen his or her ability to live or be active in a community without unnecessary dependence on the intervention of paid staff. The extent to which a person can develop and sustain natural supports in his or her life is a sign of successful inclusion in the community. The key is maintaining the balance between natural supports and specialized supports necessary to help the person pursue his or her valued outcomes.

Natural supports involve personal sharing and networking. Developing natural supports means making connections that increase the likelihood that a person with a developmental disability will participate and be included in his or her community. Specific supports may be as simple as help in furnishing a home, getting a ride to the local store or learning to use a bus. The support or teaching may be done by a community organization whose members become involved in the person’s life. It could come from neighbors who have grown to be interested in the person. It might involve reciprocal agreements, no matter how informal, like someone agreeing to shovel snow or mow the lawn for a neighbor, in exchange for a ride to the bowling alley on Wednesday nights.

Supports are often informal, and sometimes intangible. For example, friendship, encouragement, comfort, and advocacy commonly received from relationships are natural supports. Natural supports are found wherever community life is transacted: homes, work places, schools, restaurants, temples, parks, malls, libraries, clubs, etc.

There are two keys to promoting natural supports in a person centered environment. **First**, these supports should be based upon a relationship between the individual and people within the community, especially those who don't experience disabilities. **Second**, the relationship should be reciprocal, with both parties aware of the benefits to them. Natural supports are more than a simple complement to services provided by agencies that serve people with disabilities. Reciprocal relationships often result in a natural progression that allows agencies to help the individual become more included in the community. Together, natural supports and agency services help create a balanced life for the person.

## Helping Connect Natural Supports and People

The connection between natural supports and a person should be the responsibility of any staff or agency delivering supports or services, especially those involving the HCBS waiver. The existence of such connections with a community is one (but not the sole) indicator of achievement within the Individualized Service Environment. There are four simple perspectives to be kept in mind:

- Build on supports that already exist.
- People who have disabilities can be a resource within the community.
- Natural supports are a resource, similar to formally funded services (HCBS and non-HCBS)
- Natural supports may provide long term OR short term assistance - although sustaining specific natural supports for the long term can be difficult.

### 1. Build on Supports that Already Exist

A person who seeks help from the OMRDD/voluntary agency system may have vital friendships with people in a religious group, a local community center, a family down the street, the senior volunteer who comes in twice a week, or the woman living in the downstairs apartment. Any new services should allow for these relationships to continue. For example, a person who has always attended church may be suddenly cut off from this religious life by relocating to a new home or residence. In this case, people who formerly provided transportation may still be able to help fill the gap. If not, staff might find natural supports in the form of a new neighbor, a new friend, or a new church family.

*The important point is that professional or paraprofessional services should not undermine or ignore these pre-existing relationships.*

## **2. People who have Disabilities can be a Resource within the Community.**

People who have disabilities are not strictly users. They have the ability to give back and contribute, as well as take. It is in giving that one receives. The goal here is to position someone who has a developmental disability to interact with people in the community. This will *foster reciprocal relationships* between the person who has a developmental disability and other people. A person with a developmental disability can help someone who is not disabled and promote a true spirit of partnership. A consumer might be able to rake leaves for an older neighbor. Another person might be able to carry food from the van to the house as a volunteer in the *Meals On Wheels* program. Like other people in the community, a consumer could become part of an "Adopt a Highway" group.

## **3. Natural Supports are a Resource**

As a rule, support from family or community members *should be considered first*, before accessing professional resources. This generally will assist a consumer to become more closely connected with the community. In addition, when natural supports actually have the effect of lessening the scope or duration of paid services, this allows limited OMRDD resources to be directed to other people who may not have natural resources available.

Natural supports form the base of the ISE funding pyramid, the decision model that was developed for the HCBS waiver but extended to service planning decisions within the Individualized Service Environment. Natural supports should be considered the basic building blocks, building supports "from the ground up." Experience with person centered planning has shown that there are opportunities for almost everyone to access or benefit from natural resources.

## **4. Natural supports may be long term OR short term assistance.**

Natural supports can be as simple as a one-time ride to a basketball game from a friend of a friend. It can be a long term commitment such as a mother helping her daughter make dinner each night in order for her to live in relative independence in an apartment of her own. It can be as complicated as the commitment of a senior citizen center to sustain a person who loves to work with people as a volunteer, or as simple as the acceptance of a new member by a congregation.

Natural supports, once developed and put in place, may need occasional nurturing from staff. This is especially true of those which are expected to last a long time. For instance, neighbors providing car rides to church every week may like a little positive reinforcement every once in a while or somebody to check in and see if they need anything to make this volunteer effort easier. These check-ins may all reveal that things are changing and show that a new support needs to be developed to replace the one that exists. This can be due to burn-out, changes in the person's life, or a variety of other factors.

## Practical Examples of Sources of Natural Supports

*Family members* have always been a great source of support and assistance. In some circumstances, family members may have activities they wish to extend to a consumer other than their loved one.

*Some consumers* may be able to help others who are less skilled.

*Communities* have many *organizations* with members who can give needed help or provide nurturing relationships. Here are a few examples:

Many Cultural/Ethnic Groups and organizations offer services to members and new friends (e.g. African Associations, Hispanic Associations etc).

The County Office of Special Events has a yearly calendar of free events.

The Senior Nutrition Association Program (SNAP) provides on-site meals, transportation, and grocery shopping for shut-ins.

Some employers may have an interest in hiring people with disabilities.

Some employers may have an interest in taking on people with disabilities as volunteers, which often leads to supported or competitive employment.

Local high schools, community colleges, and the Cooperative Extension may also be a source for skill training.

YMCAs & YWCAs offer various programs.

Disabled Hot Line...1-800-522-4369.

Domestic Violence Hot Line 1-800-942-6906...(English); 1-800-942-6908...(Spanish).

Alcohol & Substance Abuse Hotline...1-800-522-5353.

Senior Citizens Hotline.....1-800-342-9871.

Catholic Family and Community Services is a community based organization that offers a variety of supportive services to children, adults and families.

Jewish Family Services also offers a variety of services to children, adults, and families.

*Consumers could also be of help to many of these organizations.*

## Organizing Staff Efforts to Find Natural Supports

Over the past several years, OMRDD staff have begun to understand the difference between having a responsibility “for” the consumer and having a responsibility “to” the consumer. The agency’s role is now seen more and more as *helping people with disabilities be an interactive part of the community*. The underlying premise is that all people are part of the community.

**To create networks of consumers and natural supports, staff should consider the following recommendations.**

- Go beyond traditional planning, which taps only services provided by professionals, by *first considering natural and generic supports*.
- Create opportunities to *dialogue with family members, friends, and neighbors*. Inform them of new initiatives and let them know that they are welcome to assist. They might be able to make phone calls, to be an advocate, to visit consumers, to help with fund-raisers, or just take someone for a brief outing. Brainstorm with them and they may give you new ideas.
- Create similar opportunities to *dialogue with the people and organizations* that have the potential to form partnerships with consumers. Use this relationship to educate one another about the abilities and the needs that consumers may have. Be prepared to explain things that consumers can do well.
- Encourage any *natural supports that already exist*. Strengthening current relationships may result in more natural supports. This does not replace paid services, it simply expands the circle of support for the consumer.
- Always ask “How often is the person *interacting with non-disabled individuals, family members, and friends outside the service system?*” If the answer indicates that the consumer is only interacting with paid staff and other individuals with disabilities, it may signal a need to expand relationships to include non-disabled people.



# Chapter 5 - HOUSING

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**Helen and Mary Sharon are sisters, and the two women are best friends. For many years, they lived together in a community residence in upstate New York. Although very content with this living arrangement, the sisters were overjoyed at the prospect of owning their own home. The idea for the project came from their residence manager who had observed how independent Helen and Mary Sharon were becoming.**

**Everyone knew the sisters wanted to live together in a home closer to their family. With help from a community development housing agency, the sisters located a vacant lot in their home town and built their own home, making it accessible according to their needs. It was fun because they enjoyed selecting paints and carpet colors as well as other household items.**

**Helen and Mary Sharon qualified for a federally sponsored moderate income home ownership program that would provide them with a down payment. Their service coordinator accompanied them to the bank and helped them qualify for their own mortgage. They are now sharing their dream and looking forward to a bright and happy future.**

## **Background**

In this exciting era of person centered service delivery, OMRDD is supporting an individualized, **person-controlled** approach to community housing for persons with developmental disabilities.

Historically, OMRDD has assumed responsibility for establishing housing to meet the needs of persons with developmental disabilities. In the late 1980s and early 1990s OMRDD and not-for-profit service agencies funded and developed hundreds of projects each year. This created housing opportunities in the community for thousands of people, primarily in the form of group homes serving individuals with varied needs. These group homes were developed in all areas of the state. The most popular options for community based living were intermediate care facilities, community residences, and individualized residential alternatives.

In the early years, homes developed and owned by non-profit voluntary agencies were constructed, or purchased and renovated, with funds from conventional mortgage agreements, while homes developed by OMRDD were bonded. In recent years, all group home development (with some exceptions) has been funded via bonds through the Medical Care Facilities Finance Agency (MCFFA), which is now a part of the Dormitory Authority of the State of New York (DASNY). While this approach to community housing allowed New York State to experience remarkable growth in a relatively short period of time, it also resulted in a proliferation of sometimes costly group living arrangements, often at the expense of more person centered individual alternatives.

Since the initiation of the HCBS waiver and Individual Support Services programs, OMRDD and voluntary providers have listened more closely to individual consumers and their families. More and more persons with disabilities and their families are seeking the assistance that will enable consumers to live in their own homes or apartments.

While group living may be a desire for some individuals and families, it is not and should not be the only alternative available. On the national level, persons with disabilities are advocating for the opportunities to direct their own lives. Through the Americans with Disabilities Act and the Federal Fair Housing Amendments, persons with disabilities are gaining access to affordable housing in every community. Here in New York State, OMRDD is working cooperatively with the National Home of Your Own Alliance, with banks, FANNIE MAE, and the New York State Division of Housing and Community Renewal (DHCR) to develop home ownership opportunities for persons with disabilities, while at the same time continuing to develop other housing options to meet individual needs.

“Housing” is not an HCBS service. However, OMRDD is committed to assisting people as much as possible with their individual housing needs in conjunction with HCBS and other ISE services.

To develop more person centered control over where people live, it is important to develop partnerships with *parents, not-for-profit agencies, generic housing providers, and municipalities*, as well as *the banking and finance community*. This will result in the development of housing options to meet the needs of people with disabilities while minimizing the long term fiscal impact on the citizens of New York State.

Beginning with the 1996-97 Fiscal Year, OMRDD instituted a number of changes to past practices of capital development and funding. These are incorporated in the principles outlined below.

# **Seven Major Principles**

## **1. Start with the Individual**

OMRDD's emphasis on individualized services requires a focus on developing the kinds of housing that are directly associated with the desires and needs of individuals. Before making decisions on the type of housing to be supported, it must be shown to meet the need of the individual who will live there. Housing must be developed specifically to meet the identified needs and desires of this person.

Based on identified local need, OMRDD will target geographic areas and individuals. The agency will elicit housing proposals from individuals and families, and from housing and service providers. Proposals will identify the individuals to be served, the type of housing to be developed, the cost of services to these individuals and the provider of service. OMRDD will review and evaluate each proposal based on a common set of criteria. Innovative proposals which demonstrate a public/private partnership and which minimally rely on OMRDD for service financing or capital financing will be supported.

## **2. Emphasis on Non-OMRDD Funded Housing Options**

Beginning with the 1996-97 Fiscal Year, OMRDD will encourage not-for-profit agencies to make greater use of generic funding for the development of housing options.

Agencies that seek service funding from OMRDD will gain an advantage by first accessing housing programs funded by municipalities, counties, federal housing agencies, and by state agencies other than OMRDD. During the process of allocating funds, OMRDD will encourage agencies to secure capital from other sources. Other sources of funding include the U.S. Department of Housing and Urban Development (HUD), Rural Housing Services, FANNIE MAE, New York State Division of Housing and Community Renewal, State Housing Finance Agency, Federal Home Loan Bank, municipal, county, and state affordable housing programs, banks, families, friends, and foundations.

OMRDD also recognizes its responsibility to assist small not-for-profit agencies in better serving their consumers. To this end, capital will be available on a limited basis for the development of individualized housing options by this group.

## **3. Utilization of Existing Affordable Housing Opportunities**

Through a grant with the Developmental Disabilities Planning Council, OMRDD and the Division of Housing and Community Renewal have developed a vacancy tracking system for affordable housing opportunities sponsored by DHCR in each region of the state. The list of families, persons with disabilities, and providers. As housing needs of individuals and families are identified it is essential that DDSO and agency staff evaluate the appropriateness of these vacancies and, where possible, utilize them for individuals and families.

#### **4. Initiate Collaborative Planning with Consumers, Agencies, Municipalities, and Other Interested Parties**

Meeting the long term housing needs of persons with disabilities and their families requires local, long range planning. The establishment of a housing partnership between all interested and affected parties is critical to ensuring our ability to effectively meet the needs of our consumers. To this end each DDSO has a Comprehensive Housing Strategy which identifies the housing needs of consumers within the district and identifies collaborative approaches to meet these needs. Participants in this strategic planning effort include individuals, families, OMRDD service agencies, housing provider agencies, municipalities, realtors, banks, and other interested parties. The DDSO housing strategies will serve as the basis of OMRDD planning for housing development.

#### **5. Investigate Innovative Funding Approaches Utilized in Other States**

Several states have developed innovative and cost effective methods of ensuring the continued availability of affordable housing and services for persons with developmental disabilities. OMRDD, in conjunction with consumers and voluntary providers, will closely examine programs in other states and, where appropriate, duplicate or tailor them for use in New York.

The task is achievable only through the development of local public/private partnerships - partnerships that reward innovation and have a consumer-first focus.

#### **6. Reinvestment Strategies**

Many voluntary providers have acquired sizable capital assets and maintain significant operating income by serving individuals with disabilities in various traditional program settings (both residential and day). Reviews of voluntary agency financial portfolios coupled with opportunities to downsize, convert, reconfigure, or sell off assets and programs may yield savings which would be available to invest in new housing or service options. These and other re-investment strategies will be promoted by OMRDD as a viable approach to use existing (rather than new) resources for housing.

#### **7. Increased Use of Personal Assets**

Major new possibilities exist for the funding of housing and services when state funds are used in conjunction with personal assets which may include voluntary contributions from family members and the creation of family supported trusts that are pooled, regional, or statewide. OMRDD will carefully examine these approaches as alternatives to the current funding model.

# Chapter 6 - SERVICE COORDINATION\*

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Administrative Memorandum - #2003-02, Plan of Care Support Services

Advisory Memoranda, February 17, 2004, regarding  
Medicaid Service Coordination (MSC) and Plan of Care Support  
Services (PCSS) Service Coordinator ISP responsibilities.

\*Medicaid Service Coordination is a Medicaid State Plan funded service.  
Please refer to the Medicaid Service Coordination Vendor Manual  
(May 2005) for further details regarding service coordination. The  
Vendor Manual can be found on the OMRDD website at  
[www.omr.state.ny.us](http://www.omr.state.ny.us)

\*\* (Memoranda located in the back of this manual)



E.C. is a child with a winning smile who struggles everyday to be a part of his family, have friends, and play and act the way he sees other children behave. He has a difficult time controlling what he says and does, and often becomes verbally or physically aggressive to those around him. When he becomes upset, he needs preventative intervention. When he is physically aggressive, a planned physical intervention is necessary. E.C. often does things on an impulse with little thought to what he is doing, why he is doing it, or what the consequences will be. He has been diagnosed with Moderate Mental Retardation, Attention Deficit Disorder, and Post Traumatic Stress Disorder.

Because he and his family needed help, E.C. has had psychiatric hospitalizations and other types of placement in the past. What seems to have worked best to help E.C., however, is the extra assistance his parents receive at home. Residential habilitation staff come every day to help him with his daily routine and teach him different ways of behaving. With this help E.C. is in more control of his life and able to enjoy and benefit from relationships with his family and friends.

E.C.'s service coordinator helped identify what type of help was needed, and then helped to access appropriate services. E.C. now enjoys the park and birthday parties, for example, and is learning different ways to talk with people and enjoy their company. He goes fishing, swimming, and dancing. He attends baseball games, and loves to eat in restaurants. At home he is better able to do things by himself, seems to feel better about himself, and he is beginning to take pride in his accomplishments. His life is not the intense struggle it used to be.

# Principles

As E.C. and his parents discovered, navigating the Individualized Service Environment (ISE) is often difficult. Finding and accessing even the simplest supports involves creativity, steadfastness, and sometimes formal requests and the completion of documents. Gathering information as the basis for planning and helping the person to choose his or her personal valued outcomes is the first step. Once that is done, it is necessary to design and achieve a personal network of activities, supports, and services. This task may involve discovering what services the person is eligible for and how to access and pay for them. Sometimes this can be done by the person or with help from his or her family, friends, or advocates. Many times it requires the assistance of a trained service coordination specialist.

For the HCBS waiver, the results of this process are assembled as an Individualized Service Plan (ISP). It is the service coordinator who usually helps the consumer through all or part of this process. During the enrollment process, DDSO staff are responsible for giving each applicant a list of available service coordination agencies from which to choose.

Service coordination is based on the “Hallmarks of a Person Centered Approach” to planning (see ISP, Chapter 7) and principles that keep the person and his or her aspirations and abilities the focal point for interaction with the system. Even though the extent to which a person requires assistance from a service coordinator varies, the underlying principles for assistance should not. The service coordinator:

- Is chosen by the person and advocate, just as any other support or service.
- Helps the person plan, implement, and monitor the Individualized Service Environment.
- Promotes self-advocacy and consumer empowerment.
- Stands in partnership with the person and advocate, each willing to be influenced by perceptions and suggestions from the other.
- Acts in freedom from unnecessary influences that would compromise the consumer's selection of service providers, the consumer's freedom to make informed choices, or the consumer's attainment of valued outcomes.
- Helps the person make informed choices and ensures that decisions made on the person's behalf are done so from the perspective of the person.
- Helps the person achieve valued outcomes and promote individuality, independence, inclusion, and productivity.

- Helps the person look at options, opportunities, and resources in choosing supports and services.
- Makes consumer satisfaction a priority.

**Service coordination results in three distinct products:**

- 1 - A developed ISP
- 2 - An implemented ISP
- 3 - A maintained ISP

These products can be delivered as a total package or separately at different points in time. Whether developing, implementing, or maintaining an ISP, the principles of service coordination affect and guide how each product of service coordination is achieved.

## **Products**

### **1. A Developed ISP**

The product is achieved in two stages. The first helps the person plan from a person centered approach. This includes gathering information for planning and decision making, choosing personal valued outcomes, deciding what needs to change or what needs to be in place to achieve the valued outcomes, and developing the Individualized Service Environment (ISE) or personal network of activities, supports and services. (See the ISP, Chapter 7 for more details.) The plan identifies these supports and services chosen by the consumer with the service coordinator's assistance, as well as the agency or organization that will supply them.

Second, the resulting planning information is written on the appropriate ISP form. This document becomes the person's ISP or personal plan for receiving the help they want and need to achieve their valued outcomes.

### **2. An Implemented ISP**

As a blueprint for achieving the person's valued outcomes, the ISP is put into action. Chosen activities, supports, and services are accessed as identified in the plan. The service coordinator uses knowledge of the community and available resources and uses specialized skills to successfully implement the ISP. For example, the service coordinator:

- Locates or creates natural supports and community resources.
- Encourages the person to put his or her own plan into action to the greatest extent possible.
- Locates funded services, determines eligibility, completes referrals, and facilitates visits and interviews.
- Ensures that a person has a positive relationship with the person or agency providing supports or services.

### **3. A Maintained ISP**

This product can be delivered as an ongoing service, at pre-determined intervals, or as needed. The purpose is to keep the ISP current and effective in response to consumer satisfaction or any change that affects the achievement of the person's valued outcomes and therefore the plan. A well-maintained ISP is proactive, successful, and responsive; a neglected or outdated plan can stall the momentum toward valued outcomes and often ceases to have any real meaning in the person's life. Maintaining the ISP involves a variety of service coordination activities that often include:

- Determining the person's satisfaction with the ISP.
- Supporting the person towards achievement of valued outcomes.
- Establishing and maintaining an effective communication network with service providers.
- Keeping up-to-date with changes, choices, temporary setbacks, and accomplishments relating to the plan.
- Managing through difficulties or problems as they occur.
- Keeping the ISP document current by adapting it to change.
- Reviewing the ISP at least semi-annually (this is a required activity for service coordinators serving people enrolled in the HCBS Waiver).

FOR ADDITIONAL INFORMATION ON DEVELOPING, IMPLEMENTING AND MONITORING THE ISP, PLEASE REFER TO CHAPTER 7.

### **Roles and Skills of the Service Coordinator**

In delivering all or some of these products, the service coordinator plays different roles and uses a number of skills. For example:

- Listening to understand, being patient, and taking the time to follow a person centered approach to planning.
- Working proactively within the community to develop new supports to most effectively meet a consumer's needs.
- Being a mobilizer and finding natural supports within community resources.

- Building a network of supports and services, by knowing where to access resources, and by managing funding prudently.
- Teaching self-advocacy and choice, keeping informed of problems, and negotiating or mediating solutions.
- Remaining flexible and leaving room for spontaneous ideas and choices.
- Knowing when to ask for help from supervisors or other professionals and how to use and obtain their assistance.
- Being a team player to get and maintain the best possible service and supports.
- Keeping the person's vision of their valued outcomes foremost in mind.
- Participating in ongoing training, and providing new information gleaned from such training to the consumer and advocate.

## **Number of Participants to be Served**

At the current time, there are two constraints on the number of people that can be served by any service coordinator in the HCBS waiver. The maximum number that can be served is 25, although OMRDD's funding for service coordination is based upon an average caseload of 20 people. This means that the payment level for HCBS service coordination for 20 people includes enough money to support a full-time service coordinator plus associated supervision and administrative support. The second constraint involves those service coordinators who have Willowbrook consumers on their caseloads. As explained on Page 6-8, those service coordinators may not have more than 20 people on one caseload.

With the impending consolidation of service coordination programs (CMCM and Waiver Service Coordination) the HCBS caseload maximum is expected to change. OMRDD will inform all parties of the new expectations once final policy decisions have been made. However, these changes will have no effect on the caseload constraints for service coordinators who have been chosen by Willowbrook consumers.

**Twelve Specific Tasks:**

Develop, implement, and maintain the person's ISP.

Maintain contact with the consumer as identified in the ISP.

Review the ISP and Habilitation Plans at least semi-annually.

Maintain the consumer's "primary record". (See "Individualized Service Plan")

Ensure the completion of an annual redetermination of the need for the level of care in an ICF/MR (and any necessary redetermination of Medicaid eligibility).

Document service coordination activities in the service coordinator's notes. (See "Individualized Service Plan.")

Facilitate and document a change in service coordination when requested by the consumer and advocate.

Secure or continue to secure an advocate for each enrolled consumer who requires or chooses to have one. Document attempts.

Maintain an up-to-date monthly roster of individuals receiving services who are part of his/her caseload.

Notify DDSOs of HCBS terminations, and inform the terminated individuals about connecting with follow-along services.

Ensure that the consumer's fire safety needs are carried out as stated in the ISP.

If a consumer lives in an IRA or Family Care Home, the service coordinator ensures the assessment of that person's fire safety needs at least annually. The fire safety needs of people living in their own homes should be reviewed and discussed, but an assessment is not required.

\* See "Special Notes" for specific record keeping requirements for Willowbrook consumers.

## **Qualifications**

The waiver service coordinator should have a comprehensive knowledge of community resources and a thorough understanding of the consumer's personal preferences and needs. The service coordinator also must fulfill one of the following options in terms of background qualifications:

1. A bachelor's degree<sup>1</sup> or higher in a health or human service field; and
  - a. A practicum that encompasses experience in performing assessments and developing service plans; or
  - b. One year's practical experience working with people with disabilities; and
  - c. Participation in an OMRDD approved training curriculum in service coordination.

OR

2. An associate's degree<sup>1</sup> in a health or human service field or a license to practice as a registered nurse, one year of service coordination related experience<sup>2</sup>, and participation in an OMRDD approved training curriculum in service coordination.

OR

3. Two years of service coordination related experience\*, and participation in an OMRDD approved training curriculum in service coordination.

OR

4. One year of service coordination related experience\* and an additional year of experience working with people with disabilities, and participation in an OMRDD approved training curriculum in service coordination.

## Special Notes

### Billing 30 Days Prior to Enrollment

Waiver service coordination usually begins with enrollment in the HCBS waiver but may be provided and billed for one month (30 days) prior to enrollment date, regardless of the current residence, as long as the applicant is eventually enrolled in the waiver. This "30 day" offer is not valid if the person is receiving another type of service coordination.

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<sup>1</sup>From a regionally accredited college or university, or one recognized by the NYS Education Department as following acceptable educational practices.

<sup>2</sup>Includes participating in activities such as: intake and screening, assessments, service planning, linkage and referral, advocacy, crisis intervention, follow-up, and monitoring.

\*See footnote #2, above.

## **Other Types of Service Coordination**

Consumers cannot receive waiver service coordination and another Medicaid funded service coordination program, such as comprehensive medicaid case management (provided by state or voluntary agencies), at the same time.

## **Families as Service Providers**

At times a parent or spouse of a consumer has asked to act as the service coordinator in place of an approved provider of HCBS service coordination. Family members may continue to act as consumer advocates but at this time they may not act as the service coordinator. However, state regulations which affect this issue are under review. Future policy changes may create new opportunities for family members to assume more formal responsibilities. Families with a strong interest in acting as service coordinators for a loved one should contact the local DDSO to learn the most recent decisions affecting this issue.

## **Willowbrook Entitlements Affecting Service Coordination**

OMRDD must continue to ensure that class members receive case management/service coordination at a ratio of 1:20. A full time service coordinator with even one member of the Willowbrook Class on his or her caseload can serve no more than 20 people.

As defined in Appendix I of the Willowbrook Permanent Injunction, a case manager/service coordinator for class members must be a qualified mental retardation professional (QMRP) who is either a state employee, or an employee of a voluntary agency that does not provide residential or day service to the individual. However, a class member or the class member's correspondent may chose a functionally independent case manager/service coordinator employed by the same agency that provides residential or day services, if such a person is available.

Regardless of auspice, service coordinators are to perform the functions detailed in Appendix I on behalf of Willowbrook Class members. Service coordinators should ensure that Willowbrook Class members on their caseloads receive the legally mandated services as stipulated in the permanent injunction.

## Record Keeping

### Willowbrook Requirement

Service coordinators serving class members must maintain a record of dates of attendance at team meetings, and dates of monthly consumer contacts. This information is kept by the service coordination agency, and should be made available to plaintiffs' counsel and the Consumer Advisory Board upon request. This record is maintained separate from the consumer record of services.

Monthly contacts are to be made at either the day program or at the residence. While service coordinators use discretion as to where these contacts are made, it is important that the class members be seen at both locations over the course of a quarterly period. For those in supported employment, a class member might elect to meet the coordinator at another location. That choice should be accommodated.



# Chapter 7 - INDIVIDUALIZED SERVICE PLAN

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OMRDD Advisory on Changes to the Individualized Service Plan (ISP) Format (January 14, 2005) with attached ISP Form (4/05) and ISP directions (4/05).	
Administrative Memorandum - #2005-01, Standards for Article 16 Clinics (February 18, 2005).	
*(Memoranda located in the back of this manual)	



John lives at home with his parents who are getting older. He and his parents are working to set up a home in their neighborhood where he can live and create a life for himself. John has many ideas about what he wants but he also has many problems with which he will require help in order to live in a new home and keep his job. It is much more complicated than just asking for a little support, so he and his parents are working with a service coordinator. Because he is asking for a number of supports and services, they, together as a team, are creating an Individualized Service Plan for John.

## The Individualized Service Plan (ISP)

### An Overview

The Individualized Service Plan (ISP) is evolving. Experience with the ISE has called into question a number of assumptions. What is a meaningful plan? If people just want a life, how does a “plan” fit in? What skills and qualifications are needed to effectively help a person develop a plan and then to write it? What should a plan accomplish? As people with disabilities become more “empowered,” will the role of the ISP change?

This chapter presents current thinking on the basic description and expectations of an Individualized Service Plan. It also clarifies the information that should be included, the responsibilities of the service coordinator, and the consumer’s due process rights. They are different from the expectations articulated when the HCBS waiver began. These differences are based on the experience of the past few years.

The ISP is a readable and usable written personal plan. It summarizes the help a person who has developmental disabilities wants and needs to achieve his/her own aspirations in life. These aspirations, or personal goals, are known as the person’s valued outcomes. The ISP is the blueprint for achieving these outcomes, just as an architect’s blueprint is used to build a house. The ISP is an information tool used to focus and direct efforts to assist the person with disabilities. *An ISP is developed for everyone enrolled in the HCBS Waiver, regardless of where he or she lives or what funding source is used for service coordination.*

#### **Contract with the Consumer**

The ISP is an agreement with the consumer, a blueprint for achieving the person’s valued outcomes. It holds the providers of services accountable, sets responsibilities, and spells out the consumer’s expectations or outcomes.

The person's blueprint, or ISP, is designed by using the person centered approach to planning and the guiding principles of individualization, inclusion, independence, and productivity. If skillfully accomplished, it leaves the person "empowered" and in control of the direction of his or her life. The resulting configuration of activities, supports, and services is called the person's Individualized Service Environment (ISE). The ISE uses natural and community supports as much as possible. (See Special Notes for more detail on "A Person Centered Approach to Planning.")

As a blueprint for achieving the person's valued outcomes, the ISP communicates and coordinates important information. It is, therefore, a document critical to the person, his or her advocate, service coordinator, service providers, managers, and administrators. The ISP is kept up-to-date as the person's life and decisions change.

If the ISP becomes a repository of too much background information, the valued outcomes may be overshadowed. The person's outcomes are of primary importance. Other documentation should not compromise or obscure these outcomes.

The consumer is the best person to decide if the ISP is working. Sometimes he or she will need help making this decision. In such situations, the advocate, service coordinator, and others must judge from the consumer's point of view, to the best of their ability.

## **Planning - The Foundation of the ISP**

The ISP is a document. As a document it reflects the informed choices made by people who have developmental disabilities. These informed choices are the product of service planning activities.

People who are developing ISPs should begin by assuming that every individual who has a developmental disability has some capacity to make choices. People who need help making these choices may find assistance from family members, other natural supports, or involved professionals. Most often, a person will benefit from the assistance of a professional service coordinator. The service coordinator works in partnership with the person and his/her supports to design, implement, and monitor the ISP.

Planning may be straightforward or complex depending upon the person's choices, the characteristics of the consumer, and the number of supports and services. This means that some ISPs might be less substantial than in the past, and may include only one or two valued outcomes. *This range is allowable, but depends on the wants and needs of the consumer, not on administrative or management policies.*

The following **four sequential steps** provide a brief and general guide to planning. These steps would be helpful to consider even if the consumer's request seems very straightforward. They emphasize the importance of a person centered approach.

**Step 1** Gather information as the basis for planning. The consumer, often with help from others, gathers information that he or she feels will help to make planning decisions. Though listed first, this step is ongoing as discoveries are made and changes occur. The information is often personal and confidential. It can be gathered from the person, from current plans or a Preliminary ISP, or from others who know the person well. It may also be gleaned from clinical assessments and evaluations. It is rich information that represents the person in many life areas such as: *abilities, skills, talents, relationships, values, physical health, preferences, interests, safeguards, daily routine, family, cultural traditions, reactions to stress, financial needs, etc.*

<b>Four Steps to Planning:</b>
<b>G</b> ather Information
<b>C</b> hoose Outcomes
<b>I</b> dentify Needed Help
<b>D</b> evelop Services

**Step 2** Choose personal valued outcomes. The information is used to help the person decide needs, wants and aspirations. A personal outcome is 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, or getting a glass of water when thirsty.*

**Step 3** Decide what kind of help is needed, what needs to change, or what needs to be in place for the person to achieve his or her valued outcomes. These decisions help to identify the personal network of activities, supports, and services the person will need to achieve valued outcomes. For example: *help in modifying a wheel chair for a person who wants more comfort, help in choosing a neighborhood if the person's outcome is to live in a new home, help in getting to work or other locations, help in assessing risks and determining safeguards for a person who wants to manage more independently in the community, help to enlarge community experiences and opportunities for the person who wants to make new friends, or help in learning different ways to deal with stress for someone who wants to get along better with others.*

**Step 4** Develop a personal network of activities, supports and services to achieve the consumer's valued outcomes. This is the time to explore various options available within budgetary constraints. A skilled service coordinator or others assisting the individual should be able to offer a variety of possibilities and funding sources. The first and most important area to consider is help from friends, family, and community resources. Networking within the community is a valuable resource. In addition to natural supports, all funded services should also be identified. Funded resources should complement rather than replace help from friends, family, and the community. At this time, it is important to assess the compatibility of the services, activities, and supports selected to maximize valued outcomes and avoid duplication of services.

## Factors Affecting Person Centered Planning

- Sometimes outcomes are difficult to identify, especially for people who have difficulty expressing or deciding what is important in their lives, who have minimal community life experiences, or who have severe or complex disabilities. These people may feel comfortable beginning with familiar, previously identified planning outcomes or with “everyday” choices such as wearing a favorite sweater or eating certain foods more often. But as planning efforts continue and more information is gathered about the person, valued outcomes should have an increasingly positive and significant impact.
  - Though outcomes can change at any time after the plan has been designed and implemented, it is often wise not to rush or be overly anxious to make these decisions. A thoughtful process that is truly person centered takes time and should never be superficial.
  - Some identified outcomes can be sought now, others later, depending on individual priorities, choices, situations, and available resources. In addition, *there may not be an outcome for each ISE value (Individuality, Inclusion, Independence, and Productivity).*
  - Recognizing the balance between risk taking and protection from harm is usually very challenging for people in the planning process. There are a number of resources available in this area. Two are: the Core Service Coordination Curriculum, OMRDD, 1995, and The Right to Choose, Barry Warren, Ph.D., (1993). These and other resources are available from the DDSO, Office of Workforce Planning, or Service Coordination Departments.
- If the outcome’s definition is specific, clear, and vivid, the chance of attaining that outcome will improve.

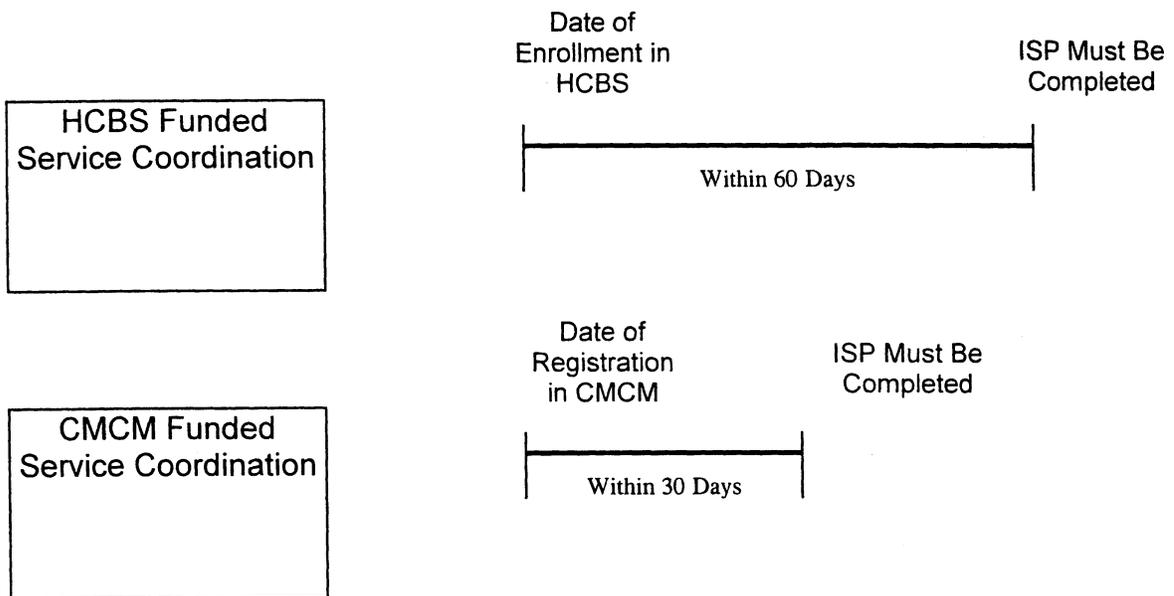
## Assembling the Individualized Service Plan

The ISP is written after the planning process has taken place. It will include enough information about the informed choices made by a person to direct his or her access to supports and services. **It does not provide details regarding how those supports or services are delivered** – such details would be in the plan for a particular support or service, for example the Residential Habilitation Plan or Day Habilitation Plan.

The ISP is also the document required by Medicaid to support or justify any HCBS funded supports or services for the person. This results in specific requirements regarding when ISPs have to be completed, what information is included and how, and how often they need to be reviewed and updated. These requirements can be found in italicized print or otherwise noted within the following discussion of how an ISP is assembled after the planning is done.

The service coordinator initially has the responsibility of coordinating the plan and writing the information on the ISP form. This must be accomplished within 60 days of the waiver enrollment date (which can be found on the person's "Notice of Decision" letter). If the person is enrolled in the waiver and receives service coordination funded by Comprehensive Medicaid Case Management (CMCM), the ISP is initially completed within 30 days of the CMCM registration date. It is possible that the planning process may not be completed by the time the ISP is due. It is recommended that the service coordinator assemble the ISP with the available information and include activities, supports, and services the person is currently receiving. Since the ISP is always kept current, it can be updated at any time.

### Timeframes for completing an ISP



**The service coordinator does not write any plan required by any other type of service. For example, the HCBS waiver Residential Habilitation or Day Habilitation Plans or Individual Residential Alternative's Individual or Site Specific Plan for Protective Oversight are not written by the service coordinator.**

### Sections Within an ISP

The ISP has two sections (see HCBS Form 07.01.97): Section 1, the Profile; and Section 2, Activities, Supports and Services. *The basic format of the ISP must be adhered to, including all sections of the plan and the sequence of each section. Service coordinators may add their agency masthead, transfer the form to word processing, format the contents of each section, or add additional sections.*

## ISP Section 1 - Writing the Profile

The profile is a narrative or “picture with words” about the person. It summarizes some or all of what was learned about the person during the planning process and must include the person’s valued outcomes. The profile communicates personal and sometimes delicate and confidential information that will assist those people helping the consumer to achieve personal outcomes with sensitivity and understanding of what is important to the person. This might include preferences, interests, needs, desires, talents, skills, choices, personality, abilities, and other areas discovered while gathering information for planning purposes.

It is sometimes difficult to determine what should or should not be part of the profile. A guideline is to choose information that the person especially wants included and information that has relevance to successfully putting the plan into action. For example, there may be a medical condition that impacts a desired outcome, or a person who wants to decrease anxiety may need specialized assistance when under stress. Highlight abilities and avoid a needless discussion of disabilities that do not relate to the person’s valued outcomes. Additional information can usually be located in a clinical evaluation or historical records.

The Profile....
Contains What the Person Wants
Is Updated With New Information
Is a Balance of Risk-Taking and Protections

Sometimes an ISP is required to be completed before the initial planning process is completed, because it takes time to get to know people before staff can assist them in making choices and formulating future plans. The service coordinator may not, therefore, have a complete understanding of the person when writing the first profile. Consequently, updating and expanding the profile is critical. This should also be done as things change or when more information is discovered as the ISP is implemented.

*Outcomes relating to safeguards that the person needs or wants are a very important part of the profile.* There is a specific heading in Section 1 of the ISP form for this information. Safeguard outcomes are not meant to be so wide ranging that routine supports, such as yearly dental examinations, are always included. Decisions about what safeguards are included should be person-based, not system-based. Again, there are resources available to help people decide the balance between risk-taking and protection. If a person lives in an IRA, the Individual Plan for Protective Oversight will be attached to the ISP form. In this situation, there is no need to repeat the same information under “Safeguards” in Section 1 of the ISP. Simply write “see attached Plan for Protective Oversight.” *Please refer to “Special Notes” on the Plan for Protective Oversight in the Habilitation chapter of this manual.*

**NOTE:** For the purpose of meeting CCM requirements, the profile is considered the “assessment” and is completed within **15 days** of the CCM registration date.

## ISP Section 2 -- Developing Activities, Supports, and Services that Define the Person's ISE

*Each activity, support, or service (regardless of funding source but depending on funding availability) chosen by the consumer is documented in Section 2 of the ISP. This information must include activities, supports and services currently being received but can include assistance the person needs or hopes to receive in the near future, as long as it is clear that the consumer agrees he or she does not expect that assistance at the current time.*

*Each entry of an activity, support, or service includes this information:*



- the person's valued outcomes for receiving the assistance,
- the name and type of the provider
- the frequency, duration, and effective date.

**NOTE:** Routine Medicaid state plan services, such as dental or pharmacy, can have a single outcome and be listed together.

Activities, supports, and services are grouped and entered according to the funding sources that are available and mirror the ISE funding pyramid (see "Natural Supports," Chapter 4). Natural supports and community resources are the "foundation" of the pyramid, with funding sources building from and strongly connected to the base. The ISE pyramid categories are:

### **A. Natural supports and community resources**

Examples are churches, the YWCA, cultural organizations, continuing education, self-help groups, health clubs, reading clinics, transportation, hobby or collectors clubs, volunteers, neighbors, grocery clerks, family members.

### **B. Medicaid State Plan services**

Examples are physician, pharmacy, laboratory, hospital, clinic, dental, physical therapy, audiological, personal care, certified home health care, durable medical equipment, day treatment, psychology, Article 16 clinics.

### **C. Federal or state funded resources (other than OMRDD)**

Examples are Vocational and Educational Services for Individuals with Disabilities (VESID), State Office for the Aging (SOFA), Housing and Urban Development (HUD), Board of Cooperative Educational Services (BOCES), Department of Health (DOH).

**D. HCBS waiver services**

These are service coordination, residential habilitation (including family care and community residential habilitation), day habilitation, prevocational, supported employment, respite, environmental modification, and adaptive devices.

**E. Other Services or 100% OMRDD funded supports and services**

Examples are Family Support Services, Individualized Support Services, and non-Medicaid service coordination.

**SAMPLE entry for category D., "HCBS Waiver Services":**

*John will receive residential habilitation services from Support Services, Inc. to help him care for himself at home, be more a part of his neighborhood, and have access to stores and services in the community. He is especially interested in learning how to prepare his meals, make new friends, join a health club, learn how to make decisions about his life, and receive assistance with his personal hygiene. As part of residential habilitation John will receive social work and psychology services in support of his outcomes. The services will be provided daily, beginning on 4/1/95, and will be ongoing with no end date at this time.*

Entries in Section 2 of the ISP are concise and identify the consumer's valued outcomes for receiving the activity, support, or service. *It is not necessary to use the narrative style, as long as the required information can be clearly understood.* Include any clinical services to be provided (as in the example above that cites social work and psychology). Be sure to include in the plan the activities, supports, or services chosen by the consumer as safeguards.

The ISP is considered the "parent" plan, or blueprint from which all other plans generate. For example, even though providers of residential habilitation collaborate with the person, advocate, and service coordinator to develop the residential habilitation plan, they would refer to the ISP to obtain written information and guidance. However, the residential habilitation plan will give more detail and specificity about what is to be provided as part of residential habilitation than that found in the ISP. All plans are collaborative, yet separate and distinct. Some examples of plans that are distinct from the ISP are day treatment plans, waiver residential habilitation plans (including plans designed under Part 671 regulation in community residences), waiver day habilitation plans, or workshop plans.

**Copies** of waiver residential habilitation, day habilitation, prevocational, and supported employment plans are attached to the ISP form. If the person lives in an IRA, the Individual Plan for Protective Oversight is also attached.

Habilitation Plans are Attached to the ISP

**Signatures** of the consumer, advocate (as appropriate), service coordinator, and service coordinator's supervisor are required on the ISP. If the consumer is unable to sign, state this fact on the line for his/her signature.

Required Signatures  
(see text on left)

## Reviewing and Updating the ISP

*The service coordinator reviews the ISP at least every 6 months, first from the date of the initial ISP and then from the last review date.* The service coordinator also ensures that Sections 1 and 2 of the ISP are kept **current**. For example, the number of hours needed for waiver residential habilitation at home could change as the person becomes more independent. Other changes could include the person's valued outcomes, life situations, needs, providers, effective dates, etc. *Although all changes are discussed with the consumer and advocate, new signatures are only needed for any "significant" changes.* "Significant" is defined by the consumer, advocate, and service coordinator. For example, a change in service provider, the frequency of an HCBS waiver service, or adding a safeguard would most likely be "significant." A change such as the use of a different pharmacy might not be considered significant. Changes in the ISP must be communicated to others with primary responsibility for providing assistance to the consumer.

ISP is Reviewed at Least  
Every 6 Months

*Though formal ISP review meetings with the person, his or her advocate, and others are not required, best practice indicates that such meetings are often beneficial* because sharing and communicating information is always valuable. These meetings could be coordinated with those held by service providers to review their own plans (i.e. residential or day habilitation, day treatment, workshop, etc.). However, the service provider must be willing to spend the needed amount of time reviewing the ISP and must be willing to invite other people assisting the person who may not normally be a part of their review meetings. It is also important to hold meetings at a convenient time.

The service coordinator's notes must be clearly written and state that the ISP was reviewed and the date of the review (refer to section on service coordinator's notes on page 7-10). Changes to the ISP must be clear and understandable. How these changes are recorded is up to the service coordinator. *Changes can be made on the plan itself or an addendum can be added. All changes to Section 2 of the form or any addendum must be dated.* It is not necessary to rewrite the ISP every year. It need only be rewritten when information is not clear or the plan is not effectively meeting its purpose. New signatures are required for new plans.

Date of ISP Review Must be  
Noted in Service  
Coordinator's Notes

The **effective date** on the ISP is the date the current version of the ISP became effective. For example, if the service coordinator completes the initial ISP, and if this version has not been completely rewritten since that time, the effective date would still be the date the original version was prepared. Any changes to Section 2 of the ISP during this time period should be dated and done as noted above. The effective date of the ISP would only change if the ISP is completely rewritten. If rewritten, some effective dates of services could predate the ISP effective date.

Effective Date

(see text on left)

# The Consumer's "Primary" Record

## Content and Organization of the Consumer's Primary Record

The person's record is kept by the service coordinator and is considered the "primary record." All other providers, such as residential or day habilitation, day treatment, or Article 16 clinics, maintain separate and distinct records of the services they provide for each consumer. The person's "primary record" is divided into four required sections, each with minimum required information. Additional sections and content information can be added at the discretion of the service coordinator: for example, a medical section or agency specific forms. The following chart applies to the "primary record" maintained by service coordinators regardless of funding source and includes CMCM record keeping requirements. *See chart on next page.*

### Service Coordinator's Notes

Keeping notes has always been a professional best practice. Notes communicate information, help to maintain coordination of services, document services provided, and substantiate any billing for services that may occur. The content and frequency of the notes vary with the funding source for service coordination.

Waiver service coordinators write notes at least monthly. Notes include services provided by the service coordinator (including ISP reviews), a brief description of the service coordinator's monthly contact with the person, and significant events or occurrences experienced by the person with disabilities. Not all services provided by the service coordinator nor all occurrences or events in the person's life need to be in a note.

Changes in the ISP should correlate with notes. All notes must be dated and signed by the service coordinator. For CMCM, include job title.

Requirements for CMCM service coordinator notes are outlined in OMRDD'S COMPREHENSIVE MEDICAID CASE MANAGEMENT MANUAL, June, 1994.

<b>The Primary Record has Four Sections:</b>
Eligibility/Enrollment Documentation
Written Information or Evaluations
The Individualized Service Plan
Service Coordination Service Notes

<b>Waiver Service Coordination Notes are Written at Least Monthly.</b>
ISP Changes Correlate with Notes
Notes Must be Dated and Signed.
CMCM Requirements

## CONTENT AND ORGANIZATION OF THE CONSUMER'S PRIMARY RECORD

### SECTION 1: Eligibility/Enrollment Documentation

#### HCBS WAIVER ENROLLMENT INFORMATION:

- The Application for Participation form.
- Documentation of Medicaid eligibility, developmental disability, and appropriate living arrangement.
- Documentation of ICF/MR Level of Care Eligibility (HCBS Form 02.02.96) and annual re-determination. Community Residences only: Administrative Memo and Physician's Authorization if enrolled prior to 9/12/93.
- Validation of the consumer's choice of self-advocacy or identification of the advocate chosen.
- The Preliminary Individualized Service Plan (as appropriate).
- Documentation of Choices form
- Copy of the Notice of Decision.

#### CMCM INFORMATION:

- CMCM Registration Form
- Withdrawal Form
- Documentation that the person has been informed of how to access services to address emergencies outside of the service coordinator's usual working hours.

#### OTHER:

- Developmental Disabilities Profile forms (DDPs) 1 and 2.

### SECTION 2: Written Information or Evaluations that were Gathered

- Examples are: clinical summaries and recommendations, service provider reports, medical information, retirement information, etc.
- For someone who moved directly from an ICF/MR to waiver enrollment, the ICF/MR final summary and post discharge plan that were prepared by the ICF/MR consistent with 42 CFR 483.440(b)(4) + (5).

### SECTION 3: The Individualized Service Plan (with attachments)

- The ISP with attachments (residential, day habilitation, prevocational and supported employment plans, CR Habilitation Plan, FC Residential Habilitation Plan, and in IRAs the Individual Plan for Protective Oversight).

### SECTION 4: Service Coordination Service Notes

## Maintenance, Retention, and Distribution of the ISP

The original ISP (with attachments) is maintained by the person's service coordinator and filed in the person's record that is kept by the service coordinator (refer to the section on content and organization of the person's record in this chapter). Copies of the ISP (with attachments) are forwarded by the service coordinator to the consumer, his/her advocate, and each primary service provider.

Medicaid Requires That Documentation be Maintained for at Least 6 years.
--------------------------------------------------------------------------

Medicaid requires that documentation **must be maintained for at least 6 years** from the date of payment to support the scope, duration, and frequency of services rendered and claimed. For this reason, the ISP must be kept for at least 6 years but not necessarily in the "active" record. If the service coordination agency changes, originals are forwarded and copies kept by the former agency.

The ISP is equivalent to a clinical record for purposes of 14 NYCRR Part 604 and 636 and their requirements, relative to confidentiality and access.

## Special Notes

### A Person Centered Approach to Planning - An Overview

A person centered approach to service design and delivery derives from a vision of a desirable future. Every planning effort and decision is made from the perspective of the person for whom the plan is being developed. The intent is to meet that person's outcomes rather than those of others. The person centered approach seeks to build on an individual's abilities and skills rather than concentrating on deficiencies.

As a guide to evaluating the "*person-centered-ness*" of service planning and delivery, OMRDD has developed the "Hallmarks of a Person Centered Approach" which incorporate the values of individuality, inclusion, independence, and productivity:

#### Hallmarks of a Person Centered Approach

- *The person's activities, services and supports are based upon his or her dreams, interests, preferences, strengths, and capacities.*
- *The person and people important to him or her are included in lifestyle planning, and have the opportunity to exercise control and make informed decisions.*
- *The person has meaningful choices, with decisions based on his or her experiences.*
- *The person uses, when possible, natural and community supports.*

- *Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity, and respect.*
- *The person's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.*
- *Planning is collaborative, recurring, and involves an ongoing commitment to the person.*
- *The person is satisfied with his or her activities, supports, and services.*

The person with disabilities is the primary decision maker. Guidance is given by his or her advocate and service coordinator, and plans are made in collaboration and consultation with others who can make a contribution to the effort. Usually a person already has a group of people who provide assistance and services (family members, friends, doctors, clinicians, habilitation staff, etc.). This collaboration becomes even more essential when the person with disabilities has difficulty clearly expressing wants and needs, since planning decisions must be made from the perspective of that person. *The person centered approach takes patience, excellent observation skills, and the development of a relationship with the person.*

A person centered approach creates a balanced view of a person, helping to look beyond the more traditional areas of our field to see other opportunities. These can include family, marriage, personal life, mental health, physical health, social life, education, recreation or leisure time, community service, retirement, spiritual, and vocation or job. This does not mean, however, that all these areas must be reflected in the ISP.

### **Lessons from Recent Experience...**

Over the past few years, thousands of ISPs have been developed. The experience has had a profound effect on how people are helped in New York State. Some of the most important new discoveries are listed below.

*The focus should be on what the person wants and needs* (rather than on what others want for them).

*An all-inclusive ISP is not for everybody.* An ISP can be as complex or as simple as the person needs or wants, each being unique to the person involved.

*Natural and community supports can flourish* within an ISP. Funded services complement supports available from friends, family, and the community. They do not replace these supports.

*The "core" group for planning* must be the consumer, the family member or advocate, and the service coordinator. Service providers, clinicians, and friends or other family members are often vital to planning, but the consumer must be the one who drives the decision making.

*Abilities rather than deficiencies must be highlighted.* Valued outcomes are emphasized instead of progress towards goals.

*Consumers' hopes and ambitions should provide the basis for their profiles.* These profiles should not be confused with psychosocial/comprehensive functional assessments or clinical summaries.

*People with severe disabilities can express what they want and need.* Professionals are learning how to listen better.

*A plan can be developed that keeps someone safe while offering opportunities,* encouraging new experiences, and respecting choices.

*The person centered approach to planning works.*

## **Due Process Rights**

The ISP for people enrolled in the HCBS Waiver is considered a “Plan of Care” under Medicaid rules and a “Plan of Services” under NYCRR Part 633.12. There are different due process rights for a consumer under the regulations that govern both.

Under Medicaid rules, a consumer enrolled in the waiver has a right to request a Fair Hearing about the Plan of Care when the DDSO terminates HCBS waiver services. (For more information, please refer to the enrollment chapter of this guide [Chapter 2].)

In addition to the Medicaid due process rights, a consumer may object to actions taken by a provider regarding his or her ISP pursuant to NYCRR Part 633.12. Thus, when a provider seeks to change or discontinue HCBS waiver services to a consumer, the procedure set forth at 633.12 is applicable.

## **Community Placement Procedures**

Community Placement Procedures, published January 1992 (Revised 2/95) apply as described in the policy to people enrolled in the HCBS waiver. This document may be obtained from the Regulatory Affairs Unit, OMRDD, 44 Holland Avenue, Albany NY 12229. The ISP and PISP can substitute for the IPP 71, “Community Services Plan” in this policy.

## **Willowbrook Permanent Injunction**

Everyone enrolled in the HCBS waiver has an ISP completed according to this section of the manual, with the following special considerations for members of the Willowbrook class:

- Each class member’s ISP is reviewed by the class member’s team at least annually and quarterly if the class member, advocate or Consumer Advisory Board (CAB) representative, or Mental Hygiene Legal Service (MHLS) so requests.

- The class member, advocate or the CAB, or MHLS, are to be invited to attend reviews of the ISP and are kept informed of the member's educational, vocational and living skills, medical condition and other matters relevant to his or her care, treatment and development.
- There shall be current, appropriate, professional assessments of each class member's needs, including where applicable, but not limited to: medical, psycho-social, habilitative, psychological, speech therapy, food and nutrition, physical therapy, and occupational therapy.
- All class member clinical records shall include a NOTICE OF RIGHTS, which describes the rights and entitlements under the permanent injunction. This NOTICE OF RIGHTS should appear in files maintained by all providers of residential and habilitative services to class members.
- ISPs should reflect comprehensive, meaningful day services each weekday and meaningful, appropriate recreation and community integration each day during evenings and weekends.
- Class members are to continue living in the community residential facilities in which they lived at the time of the entry of the permanent injunction, or in such community residential facilities with equal or smaller residential capacities. Should a move to a large facility be recommended by the team, it must conform to the provisions of paragraph 6 of the permanent injunction.
- Except in emergencies, 30 days notice should be given PRIOR to the transfer of any class member from any residential facility to another, to the Consumer Advisory Board (so long as any class member remains alive), plaintiff's counsel (for at least five years from entry into the permanent injunction); and MHLS (to the extent it represents a class member). Community Placement Procedures, published January 1992 (revised 2/95), detail the applicable notification standards for changes in residential address.

ISP Form

The following eight pages present the required content and order of presentation for the Individualized Service Plan. Although ISPs do not need to use this actual form, the content and order of presentation must be used.







## Individualized Service Plan

Name of the Person: \_\_\_\_\_ ISP Effective Date: \_\_\_\_\_

### Medicaid State Plan Services:

For each service briefly state the **name** of the provider or agency (e.g., Dr. Smith, ARC Day Treatment Center, Southern DDSO Clinic); the **type** of service (e.g., physician, day treatment, MSC, transportation, durable medical equipment, etc.); the **frequency** of the service (e.g., daily, 5 days a week, yearly); the **duration** (e.g., on-going) and **effective date** (e.g., 3/97, 5/14/99, or approximate time frame: within the past year, etc.) and the **person's valued outcome** (from Section 1 of the ISP) **or reason** for receiving the support or service.

Examples of Medicaid State Plan Services: Medicaid Service Coordination, Day Treatment, Physician, Pharmacy, Laboratory, Hospital, Dental, Audiological, Personal Care, Certified Home Health Care, Durable Medical Equipment, Transportation, other.

**Note:** Long term therapies provided in Article 16, 28, or 31 Clinic **should not** be included below. (See section "Medicaid State Plan Services: Article 16, 28, or 31 Clinic Long-term Therapies Only"). However, medical or dental state plan service provided in an Article 16, 28, or 31 Clinic **should** be described below.

Name of Provider: \_\_\_\_\_  
Type of Medicaid Service: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Provider: \_\_\_\_\_  
Type of Medicaid Service: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Provider: \_\_\_\_\_  
Type of Medicaid Service: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Provider: \_\_\_\_\_  
Type of Medicaid Service: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Individualized Service Plan**

Name of the Person: \_\_\_\_\_ ISP Effective Date: \_\_\_\_\_

**Medicaid State Plan Services – Article 16, 28, and 31 Clinics Long-Term Therapies Only (Physical Therapy, Occupational Therapy, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work and Psychiatry):**

For each service briefly state the **name** of the provider or agency (e.g., Metropolitan Article 28 Clinic, Western Article 16 Clinic); check the box to indicate the Clinic **Certification Category** (e.g., Article 16); the **type** of clinic service (e.g., physical therapy, speech pathology); the **frequency** of the service (e.g., 3 days a week); the **duration** (e.g., on-going) and **effective date** (e.g., 3/97, 5/14/99; or approximate time frame: e.g., within the past year); the **person's valued outcome** (from Section 1 of the ISP) or **reason** for receiving the support or service; and **location the service will be provided** (e.g., main clinic site, day program, or residential program).

**Name of Provider:** \_\_\_\_\_

Article 16  Article 28  Article 31

**Type of Clinic Service:** \_\_\_\_\_

**Frequency:** \_\_\_\_\_ **Duration:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Person's Valued Outcome or Reason for Receiving the Service:** \_\_\_\_\_

**At what location will the service be provided (e.g., main clinic site or at the day or residential program)?**

**Name of Provider:** \_\_\_\_\_

Article 16  Article 28  Article 31

**Type of Clinic Service:** \_\_\_\_\_

**Frequency:** \_\_\_\_\_ **Duration:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Person's Valued Outcome or Reason for Receiving the Service:** \_\_\_\_\_

**At what location will the service be provided (e.g., main clinic site or at the day or residential program)?**



## Individualized Service Plan

Name of the Person: \_\_\_\_\_ ISP Effective Date: \_\_\_\_\_

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**HCB Waiver Service Summary:** Complete a section below for each waiver service. Add more pages as needed.

For each service briefly state the **name** of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO); the **type** of service (e.g., residential habilitation, supported employment, environmental modification); the **frequency** of the service (billing unit of service); the **duration** (e.g., on-going) and **effective date** (e.g., 1/1/99) and the **person's valued outcome** (from Section 1 of the ISP) or **reason** for receiving the support or service.

<b>Name of Provider:</b> _____
<b>Type of Waiver Service:</b> _____
<b>Frequency:</b> _____ <b>Duration:</b> _____ <b>Effective Date:</b> _____
<b>Person's Valued Outcome or Reason for Receiving the Service:</b>
_____
_____

<b>Name of Provider:</b> _____
<b>Type of Waiver Service:</b> _____
<b>Frequency:</b> _____ <b>Duration:</b> _____ <b>Effective Date:</b> _____
<b>Person's Valued Outcome or Reason for Receiving the Service:</b>
_____
_____

<b>Name of Provider:</b> _____
<b>Type of Waiver Service:</b> _____
<b>Frequency:</b> _____ <b>Duration:</b> _____ <b>Effective Date:</b> _____
<b>Person's Valued Outcome or Reason for Receiving the Service:</b>
_____
_____

**Types of HCB Waiver Services:**

residential habilitation	prevocational services	day habilitation
supported employment	environmental modifications	respite
adaptive devices	plan of care support services	
fiscal/employer agent	consolidated supports and services	
transitional services	family education and training	



# ISP Instructions

## I. SECTION BY SECTION INSTRUCTIONS

### **The Header**

#### **Name of the person:**

Name of the person for whom the ISP is written.

#### **ISP Effective Date:**

Date the service coordinator wrote the ISP. This date does not change until a new ISP is written.

#### **Medicaid Number or CIN Number:**

The person's Medicaid number, also known as the person's Client Identification Number.

#### **ISP Review Dates:**

List each date the ISP was reviewed. The ISP is reviewed at least every 6 months, first from the month of the initial plan and then from the month of the last review date.

### **Section 1:**

#### **The Profile, the Person's Valued Outcomes, and Safeguards**

##### **Profile:**

**The Profile** is a narrative about the person. It includes selected person centered information about the person discovered during the planning process. The profile may address abilities, skills, preferences, accomplishments, relationships, health, cultural traditions, community service and valued roles, spirituality, career, recreational interests and enjoyment, challenges, needs, pertinent clinical information, or other information that impacts how supports and services will be provided.

The profile tells the reader about the person and his/her current needs and wants. It assists those helping the person provide supports and services with an understanding and sensitivity to what is important to the person. This information is necessary to successfully put the plan into action.

### **The Person's Valued Outcomes:**

List the person's valued outcomes that derive from the profile. They are the person's chosen life destinations. There must be at least one valued outcome for each waiver habilitation service (residential habilitation, day habilitation, prevocational services, and supported employment) that the person will be receiving. The Habilitation Service is "authorized" only where the service relates to at least one of a person's valued outcomes. List the outcome again for each appropriate waiver habilitation service in the "HCB Waiver Service Summary."

### **Safeguards:**

State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. The Habilitation Plans, or referenced documents, will provide greater detail about how safeguards are ensured within the context of the respective service. The "Individual Plan for Protective Oversight" can be referenced in the safeguards section for people who live in an IRA. Fire safety must be discussed in the safeguard section of all ISPs unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs.

### **Section 2:**

#### **The Person's Individualized Service Environment**

Section 2 of the ISP lists all the supports and services received to help the person live a successful life in the community and pursue his or her valued outcomes. Supports and services are coordinated to keep the person healthy and safe from harm.

#### **Natural Supports and Community Resources:**

Natural Supports and Community Resources exist in the community for everyone. They are routine and familiar supports that help the person be a valued member of his or her community and live successfully on a day-to-day basis at home, at work, at school, or in other community locations.

List people, places, or organizational affiliations that are a resource to the person by providing supports or services, such as family, friends, neighbors, associations, community centers, spiritual groups, school groups, volunteer services, self-help groups, clubs, etc. Include the name of the person, place or organization and a brief statement about what is being done to help the person.

Assistance related to achieving a valued outcome should be noted. It is not required to include the frequency, duration, and effective date for the support or service as you would for the funded services.

Example entry: “John’s neighbor, Harry Smith, helps John with his grocery shopping every Saturday”; or “John is a member of the local fire department and attends most of the scheduled activities, especially the Tuesday night meetings.”

**Funded Services:**

**Medicaid State Plan Services** are those services that a person can access with his or her Medicaid card. These services include **Medicaid Service Coordination**, physician, pharmacy, laboratory, hospital, dental, physical therapy, audiological, durable medical equipment, day treatment, and psychology.

Medical, nursing, or dental state plan service provided in an Article 16, 28, or 31 Clinic should be described in this section.

**Medicaid State Plan Services – Article 16, 28, and 31 Clinics Long-Term Therapies Only, (e.g., Physical, Occupational, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work, and Psychiatry)**, are services that are provided through clinics. In this section, the Service Coordinator must indicate which type of Clinic (e.g., 16, 28, or 31), is providing the service. Also include at what location the service is being provided, (e.g., main clinic site, day or residential program).

**Federal, State, or County Services** are government services funded by agencies other than OMRDD. These include Vocational and Educational Services for Individuals with Disabilities (VESID), State Office for the Aging (SOFA), Housing and Urban Development (HUD), Board of Cooperative Educational Services (BOCES), Department of Health (DOH), Department of Social Services (DSS), public schools, etc.

**HCBS Waiver Services** are those services funded by the Home and Community-Based Waiver. These are residential habilitation, day habilitation, prevocational services, supported employment, respite, adaptive devices, environmental modifications, family education and training, plan of care support services, consolidated supports and services, fiscal/employer agent, and transitional services.

**Other Services or 100% OMRDD Funded Supports and Services** are services that do not fit in the other categories or are solely funded by OMRDD and have no Medicaid funding. These are Family Support Services, Individualized Support Services, and some Community Service Plan services such as Non-Waiver Enrolled service coordination.

**Required Information for Medicaid State Plan Services; Federal, State and County Funded Resources; HCB Waiver Services; and Other or 100% OMRDD Funded Services:**

- **Name of the provider or agency** (e.g., Dr. Smith, Community General Hospital, VESID, Housing and Urban Development, Sunshine County ARC, or DDSO).
- **Type of provider or type of service** (e.g., physician, cardiologist, educational, residential habilitation, housing, day treatment, or MSC).
- **Frequency of the support or service.** (e.g., daily; 3 days a week, monthly, twice a year, as needed, or one time purchase.) **The frequency of an HCB Waiver Habilitation Service must correspond to the billing unit of service.**
- **Duration of the support or service.** This means for how long the assistance is expected to last. If the service does not have an expected end date, write “on-going.”
- **Effective date of the support or service.** This is the date the current provider first provided the service. Effective dates may be difficult to obtain for some Medicaid State Plan Services; Federal, State and County Funded Resources; or 100% OMRDD Funded Services. In this situation, enter the approximate time frame (last few years, over 10 years, within the past year, etc.) However, HCB Waiver Services and Medicaid Service Coordination must have the exact and correct effective date. A HCB Waiver Service provider's billing will be jeopardized if the date the provider billed for the service is prior to the effective date on the ISP.

For a one time service or purchase, such as environmental modifications and adaptive devices, the anticipated purchase/completion date is used.

- **The reason or valued outcome** for receiving the support or service. e.g., to monitor seizure activity, to help obtain an apartment, to learn how to get from home to work.

If a service or support is helping the person to achieve a valued outcome (person’s chosen life destination) as identified in the profile, then the outcome is required information for this entry.

If a service or support is not directly helping the person to achieve a valued outcome as identified in the profile, then a “reason” for why the person is buying a particular support or service is required information for this entry.

**Note: The above information (name and type of provider, frequency, duration, and effective date) must be accurate for HCB waiver services since the ISP substantiates the payment of these services.**

- List in each entry any clinical services received by the person within a service. For example, a person may receive psychology, physical therapy, or nursing as part of day treatment, residential habilitation, day habilitation, or an Article 16 Clinic. Coordination of Medicaid funded clinical services is critical and must not be unnecessarily duplicated. Ensure that Article 16, 28, and 31 Clinical services are coordinated with and do not duplicate other identical clinical services. For example, ensure that psychological services from an Article 16 Clinic do not duplicate identical psychological services within HCBS Waiver residential habilitation.

**Names of Service Providers receiving copy(s) of the ISP and attachments:**

The MSC should list who has received a copy of the ISP and when it was sent.

**Signatures:**

- the person,
- advocate (if the person is not self-advocating),
- service coordinator, and
- service coordinator’s supervisor.

Signature lines must not be blank. If the person is unable or unwilling to sign, this should be noted on the signature line. If the person is a self-advocate and the advocate is not signing, “self-advocate” should be written on the line. Signatures must be dated.

**Attachments:**

- waiver residential habilitation plan
- waiver day habilitation plan
- waiver prevocational services plan
- waiver supported employment plan
- waiver consolidated supports and services (CSS) plan
- individual plan for protective oversight if the person lives in an IRA
- Medicaid Service Coordination Activity Plan
- Clinic treatment plan (or written recommendations from Article 16, 28 or 31 clinics)

**II. FORMAT AND TIME FRAMES**

The first ISP is written within 60 days of the HCBS Waiver enrollment date (which can be found on the HCBS Waiver Notice of Decision form) or within 60 days of the MSC enrollment date, whichever comes first.

## **Updating the ISP**

The service coordinator ensures that the ISP is kept current (up-to-date), adapted to the changing outcomes and priorities of the person, as growth, temporary setbacks, and accomplishments occur.

If the ISP is not re-written and dated, changes may be made by attaching an **addendum**. The addendum must include the name of the person, the date of the ISP to which it is attached, the date of the change, the new or changed information, and the signature of the service coordinator.

The addendum requires new signatures if there are changes to HCB Waiver Services or the change is considered “significant” by the person, advocate, and service coordinator.

Changes in the ISP must be communicated to day treatment providers and HCB Waiver Habilitation service providers (residential habilitation, day habilitation, prevocational services and supported employment). If an addendum is used, distribute copies.

## **Reviews of the ISP**

The ISP is reviewed at least every 6 months, first from the month of the initial plan and then from the month of the last review date. ISP reviews must be held by the end of the 6<sup>th</sup> month.

The service coordinator is responsible for coordinating a review of the ISP and making any needed changes to the plan as the result of the review.

At least annually, the ISP review must be a face-to-face meeting with the service coordinator, consumer, advocate and major service providers (residential habilitation, day habilitation, prevocational, supported employment, or day treatment). Each major provider invited must send a representative.

## **Maintenance, Retention, and Distribution of the ISP:**

The signed ISP (with attachments) is maintained by the person’s service coordinator and filed in the service coordination record.

Copies of the signed ISP (with attachments) are forwarded by the service coordinator to:

- the person,
- his/her advocate,
- waiver residential habilitation,
- waiver day habilitation,
- waiver prevocational services,
- waiver supported employment,
- day treatment,
- respite,
- article 16, 28, or 31 clinics,
- fiscal/employer agent (CSS participants only)
- and others, (with the consent of the person)

HCBS Waiver habilitation providers (residential, day, prevocational, and supported employment) have 30 days from the date of the ISP review to make any necessary revisions to the habilitation plan and send the completed and revised plan to the service coordinator.

The service coordinator has 45 days from the date of the ISP review to send the full ISP or addendum and any revised habilitation plans to the consumer, advocate, and appropriate service providers. If the 45 day time frame cannot be met because of delays in obtaining the necessary signatures, the MSC service coordinator can send copies of the ISP to all parties without signatures. The ISP must be sent with a note indicating that the original document with the required signatures can be found in the individual's Service Coordination record.



# Chapter 8 - HABILITATION SERVICES

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## Background

The purpose of the Individualized Service Environment (ISE) is to help people with developmental disabilities participate in meaningful activities. Habilitation services, plus generic services and natural supports, are the elements of the ISE that help people by promoting their independence and involving them in their communities.

Even though a person with a developmental disability has an avid interest in certain activities, he or she often needs assistance in order to take part in them. *This is essentially what habilitation services are - helping a person learn the skills and get the supports needed to pursue personal interests and aspirations.* A basic principle is to do all this in a way that still leaves the person in as much control of his or her life as possible. The hallmark of a good habilitation service is to deliver the necessary assistance in a helpful way without interfering with the person's lifestyle.

A prime example is the support needed at home to help someone maintain a job. The important outcome is to keep the job. The person may need help with a morning routine in order to get to work on time in a calm frame of mind. Sometimes this means that staff working in the home must actually do certain "daily living" tasks for the person rather than take the time to teach him or her to complete them independently. This is key - keeping the focus of the staff action on the outcome of value to the person.

Four different habilitation services are available through the HCBS waiver or through non-Medicaid funding. These have been labeled **residential habilitation, day habilitation, prevocational services** and **supported employment**. They are described in the following pages. This chapter was written to provide a better understanding of habilitation - both to those who receive services and those who plan and provide the services.

### 4 Distinct Habilitation Services

Residential Habilitation  
Day Habilitation  
Prevocational Services  
Supported Employment

Each kind of habilitation service is based on the Person Centered Approach and Individualized Service Plan (ISP) described in Chapter 7. The ISP is the "parent plan" that identifies the specific directions the person wants to take in life and the outcomes he or she wants to achieve along the way. Habilitation services are intended to help the person attain the personal goals or outcomes that are stated in the ISP. **The specific supports, assistance or services are described in a "Habilitation Services Plan" that is attached to the ISP.**

### Habilitation Services in Transition Since 1991

The greatest expansion of habilitation services has been seen in residential habilitation, which has grown by more than 15,000 people in 18 months. With little time for a gradual transition, providers were asked to make quick alterations from program models into person centered service packages. The lessons learned by staff who were part of those changes have contributed to the information contained in this edition.

## Residential Habilitation

Lillian has lived in eighteen residential programs, including two developmental centers, two psychiatric centers, one jail, and a variety of group homes over the past forty-seven years of her life but has recently moved into her first home. She has a one bedroom apartment where she cooks for herself, entertains occasionally, makes her own doctor appointments, and receives residential habilitation to learn budgeting, how to get around her neighborhood and community, and conversational skills.

Recently Lillian expressed that she is happier now than ever before in her life. She explained that, "if a person is put in the right place, not the wrong place, that person can change a lot. It's the environment and the surroundings and the people who work with you that can help you make that change. I kept telling them at Wassaic that I wanted to live in my own place, just like this." For Lillian, that day has come.

Residential habilitation is usually provided where a person lives. In the ISP a person has identified meaningful outcomes. If the supports or activities needed to pursue an outcome typically occur in the home, then the outcome becomes part of the residential habilitation service the consumer will "purchase."

It is often difficult to clearly understand the activities or services which are most suitable to pursue an outcome in someone's ISP. Therefore, the residential habilitation provider may need to assess the consumer to better understand his or her skills. For example, if a person wants to be as independent as possible at making meals, the consumer may initially be given opportunities to use appliances, prepare food, or handle plates and utensils. Once the assessment is completed, a decision can be made about the activities that need to be utilized.

Residential habilitation is not limited to staff teaching a consumer a new skill. Frequently staff will **do for** the consumer. For example, if the person would like to dress himself, staff may do the more complicated steps such as buttoning or zippering. Interventions by staff, natural supports (e.g. family or friends), or generic services (e.g. public bus service or DSS) may complement each other to assist the person in pursuing the outcome he or she desires.

Providers should note that *it is more important to have a meaningful life than to be proficient in every activity of daily living*. A person may wish to volunteer at the Red Cross but may not be independent in toileting. It is more important to allow the person to volunteer, with toileting supports put in place from either friends or paid staff, than to restrict the consumer until he or she becomes independent in toileting.

Residential habilitation services may be provided at any time of day, as long as similar Medicaid funded services, e.g. day habilitation services or state plan services, are not provided at the same time.

### QMRP Role in Residential Habilitation

In the delivery, management, or supervision of residential habilitation services, the provider must be able to demonstrate the involvement of a QMRP as that term is defined in 42 CFR 483.

Descriptions of the services that are commonly considered part of residential habilitation can be found on page 8-5, under “Examples of Activities and Services.”

## Day Habilitation

**John’s passion was trains. Whenever he was asked what kind of job he’d like, his response was always “train conductor,” or “drive a train.” His day habilitation staff were frustrated, knowing how few opportunities existed for work on trains and railroads. They encouraged John to get involved in the community in other ways. But John, already in his middle years, could not be swayed from his interest, and did not readily participate in other activities.**

**Fortunately, there was a train museum in John’s city, run mostly by volunteers, whose passion was to restore old trains. John became a volunteer, too, and was readily accepted by the others. John became the main person repainting one of the locomotives, was featured in their newsletter for his work, and was extremely proud of “his train.” The very passion that had been seen as a stumbling block to progress became the key to John’s finding a group of community friends and taking on a valued role among them.**

Day habilitation services help individuals achieve satisfying and rewarding connections and relationships within their communities. These services are very flexible and can be provided almost anywhere in the community an individual wishes to learn new skills. They can be combined with many other activities or services, such as employment or traditional day services. Day habilitation services are key in assisting individuals with daily life activities. *Day Habilitation services must be described in the habilitation plan.*

Day habilitation services are typically delivered to the individual in settings separate from his/her home. However, some activities naturally flow from one setting to another, for example preparing shopping lists and then shopping for needed items. The *general* guideline in determining how much day habilitation occurs in an individual’s home is that *at least 51%* of the service involves working with the individual outside of his/her home (see special note on page 8-16). Otherwise, the service may be more properly considered residential habilitation. A list of typical activities in day habilitation is given in NYCRR Part 635-10.4(b)(2). Other examples are given on page 8-5 and 8-6.

Because day habilitation is not a “program” but rather a compilation of supports and services, *there is no requirement that the services be provided in a separate building or space dedicated to day habilitation.* However, if a site is leased or purchased for the purpose of offering day habilitation services, an operating certificate is required under NYCRR Part 635-7.5.

An individual may receive day habilitation services in addition to other non-residential services such as clinic or day treatment, or vocational services such as sheltered workshop, prevocational or vocational services (waiver or non-waiver). However, an individual may only receive one service at a time. For example, an individual may receive day habilitation services and be employed at a sheltered workshop. However, he or she may not receive day habilitation services while performing subcontract work tasks. Day habilitation services may, however, reinforce skills and activities that the individual is learning while working.

**Receiving other services in addition to Day Habilitation...**

Waiver *day habilitation services are not specifically vocational in nature*. Waiver prevocational and waiver supported employment services (described below) primarily focus on supports to individuals in preparing for, obtaining and retaining employment. However day habilitation services do support individuals in their development and attainment of life goals, including what may be career goals.

**Day Habilitation is not...**  
... vocational in nature

**But Day Habilitation can teach about...**

- ... employment opportunities
- ... what people do for jobs
- ... how to volunteer
- ... how to get to a job, etc.

As noted above, day habilitation services are not provided while the individual is working at a job. Instead, supported employment provides an individual with services during employment. However, situations may arise in which activities occur during day habilitation that result in some type of payment or economic benefit. When the primary purpose of the activity is habilitative in nature, as described under “allowable activities,” and the payment or economic benefit is incidental to the activity, it can be considered a legitimate day habilitation service. In these cases the individual must be compensated in accordance with Department of Labor regulations. In no case may Medicaid funds (i.e. the provider’s day habilitation reimbursement) be utilized to pay an individual. When the service is clearly vocational and the individual is being paid to perform a job, it should *not* be considered a day habilitation service, but rather prevocational or supported employment service.

**Day Habilitation activities may result in incidental income, but there are rules...**

Day habilitation services may be used to “wrap around” an individual’s employment to assist the person in developing meaningful leisure time activities, exploring new career goals, and learning to manage time and activities. In this way habilitation services can assist the individual in developing an integrated assortment of activities and interests that lead to a productive life. This reduces reliance on paid program services to fill up their time while not employed.

Day Habilitation can be “wrapped around” employment or prevocational services.

Day habilitation services may be provided individually or in groups. When the activity or service is provided to a group of individuals, it must be incorporated into the habilitation plan and ISP of each of the individuals participating.

## Examples of Activities and Services for Residential and Day Habilitation

The following examples, found in NYCRR Part 635.10, illustrate some, but not all, of the activities and services available through residential and day habilitation. Providers are given the flexibility to be creative when developing activities that enable the consumer to pursue valued outcomes. The activities may entail doing a task for the person, as well as helping the consumer to learn or maintain a skill.

In each of the examples below, only one habilitative activity is cited to correspond to a valued outcome from the ISP. *In actual practice, a service provider could choose more than one activity to help the person enjoy a single outcome.* For example, someone who would like to spend more time with a special friend may need assistance using transportation, communicating (telephone), and using money.

1. The ISP states that one of the person's valued outcomes is to spend time with a particular friend. The habilitative activity(ies) put in place to enjoy this outcome may be to teach the person **how to socialize with other people**, such as people at the friend's home, or the **behavior** that may be expected by the community at large.
2. The valued outcome indicates the person likes to stay in touch with family members who live far away. The habilitative activity may be to improve **communication skills** such as language development, use of the telephone or writing letters/sending cards.
3. One person may have a valued outcome to live alone, another person's valued outcome may be to be as independent as possible in a supervised setting. For those examples, the people may be taught **housekeeping chores** such as menu planning, cooking, laundry or shopping.

4. The person's valued outcome may be to dress well or "look great." Possible activities could be to learn **personal hygiene and grooming skills** such as bathing, hair care, toileting, or choosing clothing.
5. Spending time with family could be a valued outcome for many people. Big meals, frequently associated with family gatherings, may create a conflict for the consumer who battles a weight problem. The habilitative activity for this person may include belonging to a weight control support group where occasional large meals could be included as part of a therapeutic diet plan, along with exercise if that were deemed appropriate.
6. Being fit and healthy is a valued outcome for many people. **Health promotion**, focusing on elements such as **diet and exercise**, may be a habilitative service used to help achieve this goal.
7. Learning to **use money**, such as using cash or budgeting, would be a habilitative activity for someone whose valued outcome is to use community resources such as clothing stores or restaurants.
8. Developing **personal safety skills**, such as when and how to leave a building in case of fire, would also be a typical part of the habilitative service for anyone with a valued outcome of using the community or living as independently as possible.
9. Crossing the street, using the bus, or learning the route to a friends house are all examples of **using public transportation** resources.
10. Improved use of **leisure time** that is **not merely a diversion** can enhance a person's life. Examples are pursuing interests such as hobbies, fishing, painting or doing volunteer work.
11. Developing an awareness of **personal responsibility and self improvement** by learning self-advocacy, the responsibilities that accompany choices or understanding sexuality are examples of services for someone who lives and works in the community.
12. Assistance with **problem resolution and emergencies** can improve problem solving skills for the person who, for example, may be stranded at a bus station or would like to be more self-sufficient during a personal medical emergency.
13. Provision of **personal care** type activities, like changing diapers, cutting nails, or giving medication - i.e. "doing for a person" - can be a habilitative service **only if** the person is not receiving Medicaid state plan personal services at the same time of day.

14. Provision of **on-site professional services** which are part of the development or implementation of an ISP may be allowed if they are provided by qualified members of a clinical discipline.

The services of professional clinical staff may be directed toward instruction, training, assistance, modeling, program design, and other consultation services, in support of habilitation staff in accordance with the ISP. *Such services may also be direct services to a person.* Clinical staff may include social work (excluding service coordination), nursing and health care, physical and occupational therapy, behavioral and psychological services, speech pathology and audiology, and nutrition services.

## Prevocational Services

**Cal has recently moved to a new community IRA from an ICF/MR. He used to work at a sheltered workshop. Although his work productivity has never been substantial, Cal has always had a strong work ethic, and his paycheck, although small, has always meant a lot to him. He was very interested in trying a “community job” when he moved to the small IRA, and was given an opportunity to join an enclave working in a doughnut factory. His pay is still quite low, based on his very slow pace of work, but his smile and cheerful willingness to take on any job and work at it to completion make him a valued employee and co-worker. Without the extra support of prevocational services, Cal could not have qualified for this enclave.**

Prevocational services address the individual’s vocational interests. They assist individuals who are interested in joining “the world of work” but whose skills are such that they may not expect to obtain competitive employment within the next year.

*Prevocational services must be described in the ISP.* The individual may or may not perform work for which he or she is paid while receiving prevocational services. Prevocational services include support and training related to the ability to obtain and retain employment, excluding training on job tasks per se.

Service areas may include following directions, attending to task, task completion, problem solving, or safety on the job. Services may focus on learning how to relate to supervisors and co-workers as well as productivity demands in the work place. In all cases the purpose of the service is habilitative.

In general, prevocational services are aimed at providing opportunities for individuals with limited work related skills to participate in age appropriate tasks to enhance their ability to obtain integrated employment.

## Eligibility

Prevocational services are provided to individuals who have a vocational interest but who are not expected to be capable of securing competitive employment within one year (although they may be capable of receiving supported employment services). The general test for eligibility under HCFA guidelines is that the individual must have a demonstrated or assessed earning capacity of less than 50% of the Federal minimum wage - or prevailing industry wage, whichever is greater - (on the specific tasks to be done during prevocational services) and be expected to continue at this earning capacity while receiving services.

Prevocational services under the HCBS waiver are only available to persons who have previously been discharged from a Nursing Facility, ICF or ICF/MR.

To receive Medicaid funding for prevocational services under the HCBS waiver *there must be documentation indicating that these services are not available to the individual under Section 110 of the Rehabilitation Act of 1973 as amended*. A letter from VESID or a note by the Service Coordinator documenting that VESID reports funds are not available at the time is considered appropriate documentation. Prevocational services under the HCBS waiver are only available to persons who have previously been discharged from a Nursing Facility, ICF or ICF/MR. People not meeting this requirement can still receive prevocational services, but not through the HCBS waiver.

*Often, the difference between a day habilitation service and a prevocational service is subtle and not clear-cut.* Individuals may choose to volunteer in the office at the Red Cross to enhance their social network, to offer something back to the community, or to have a regular day out doing something different. The activity may be completely unrelated to any vocational goal, and support services would be most properly considered as day habilitation. Other individuals may volunteer in the same office because, in addition to wishing to volunteer their time, they want to sample various work settings to see if they like them, to learn more about office routines with a view to later office work, or to add experience to their resume. The support services in each case may be identical: assisting the individual in becoming familiar with the new environment, responding appropriately to the demands of the environment and becoming an integral part of the environment. In the latter case the support services could properly be considered either prevocational or day habilitation services because the focus is on future employment.

In a situation where individuals are paid for their activities, the services are properly considered to be prevocational rather than day habilitation. For example, an individual may be employed as part of a "mobile crew" doing lawn care. The productive contribution to the crew may be minimal, as reflected in earnings of \$.75 an hour. The prevocational services received may focus on such matters as staying with the activity to be accomplished, finding and putting away tools correctly, asking for direction, understanding when a job is completed, being a team member, or relating to other team members and customers. Specific tasks such as raking techniques would be considered part of the job and not part of the habilitative service.

If directly paid for an activity, it is pre-voc, not day habilitation

## Supported Employment

Ethel's sheltered workshop was "downsizing." Due to her negative attitude toward others and her limited interest in most work activities, Ethel was not considered for regular supported employment. The only work she had ever really enjoyed was ironing clothes, which she had done many years at the Developmental Center. This was not an alternative now, because Ethel could not adjust her ironing techniques to the newer style irons and synthetic clothing.

The possibility of employment seemed impossible. Ethel was set in her ways, negative, and verbally abusive. The only thing that came to mind was that Ethel kept the neatest clothes closet anyone had ever seen. She loved arranging her clothes and hanging them in the closet, and all her blouses and skirts, etc. were arranged in order and neatly stored.

Starting with this single interest and skill, waiver supported employment staff were able to find Ethel a part time job at a used clothing shop, unpacking and hanging clothes and keeping the clothing neat on the racks. Very intensive job coaching was still needed to assist Ethel with the interpersonal skills needed at the shop, but it was a local shop where most people knew each other, and that really helped. The fact that Ethel was "quirky" was more tolerable there than at a regular retail store, and the presence of the waiver job coach was crucial to success during the first rough months.

Supported employment services assist individuals in finding and keeping employment that is meaningful to them. Under the HCBS waiver, supported employment services provide appropriate staff and/or material to individuals to obtain and maintain paid employment. The services take place in integrated work settings which provide regular interaction with individuals who do not have disabilities and are not paid to offer services to the individuals receiving supported employment.

Services may include any activity needed to sustain employment such as supervision, training and transportation, assessments and reassessments, job coaching and skill training. Working with employers on behalf of service recipients is also part of this service. A specific list of allowable activities is given in NYCRR Part 635-10.4(d).

Supported employment services may be provided at the intensive or extended level:

*Intensive* supported employment services are those services and/or interventions that are required to assist a person to successfully obtain and develop the skills to retain employment. These services are provided until a level of “stabilization” occurs where a person is able to sustain employment with less frequent interventions.

*Extended* supported employment services are those services and/or interventions that are required to enable a person to maintain employment once the intensive phase of job training services is completed. These services include continuing or periodic services provided at least twice monthly at or away from the work site as required to maintain the person’s employability.

The transition from an intensive to extended phase is usually a gradual one. For example, when an individual first obtains a job, the job coach will typically spend the entire work time with him or her, helping the individual learn the job tasks as well as learn to adjust to the work environment (things such as lunch and break time routines, communication with supervisors, and so on). Gradually the job coach will spend less on-site time -- perhaps getting the individual “set up” and then returning toward the end of the day. When the job coach, the employer, and the individual are comfortable that the individual has reached his or her capacity for working independently for a routine day, transfer to extended services is considered. For some individuals this capacity may allow for job coach visits only twice monthly to make sure everything is still stable. For other individuals the job coach may be required to continue to be present for tasks or routines for which the individual continues to need direct assistance.

### **Eligibility**

Supported employment services under the HCBS waiver are provided to individuals for whom competitive employment has not traditionally occurred or has been interrupted or intermittent as a result of severe handicaps and who need intensive ongoing support to perform in a work setting. These waiver services are only available to individuals who have previously been discharged from a Nursing Facility, ICF or ICF/MR. Additionally, there must be documentation indicating that these services are not available to the individual under Section 110 of the Rehabilitation Act of 1973 as amended. A letter from VESID or a note by the Service Coordinator documenting that VESID reports funds are not available at the time is considered appropriate documentation. People not meeting these requirements can still receive supported employment services, but not through HCBS funding.

Supported employment services funded through the HCBS waiver are only available to individuals who have previously been discharged from a Nursing Facility, ICF or ICF/MR

# The Habilitation Plan

## Definition

Each habilitation service (Residential and Day Habilitation, Prevocational Services and Supported Employment) has a separate plan which is written by the habilitation provider within **60 days of the start of services**. The plan is based upon the ISP. It is written in collaboration with the consumer, service coordinator and advocate and is updated when new information is discovered which will further the consumer's chances to reach a valued outcome.

## How to Develop

1. **The activities in the habilitation plan emerge from the outcomes** (personal preferences) appearing in the ISP. The habilitation plan writing process **begins** with an understanding of the person - what he or she wants in life, what he or she prefers to do.

Example - Christine may have a close friend. Spending time with her friend may be a valued outcome that appears in her ISP. A second person, John, depends upon staff for assistance in all phases of his life. Although little is understood about his preferences, someone has noticed he likes animals. Thus, his valued outcome is to have an opportunity to be around animals.

<b>3 Steps to a Habilitation Plan</b>
1. Determine what the person wants in life and prefers to do.
2. Correlate ISP outcomes to habilitative activities.
3. Habilitation provider adds professional recommendations.

2. **The habilitative activities which correspond to the ISP outcome(s) then become the foundation of the habilitation plan.** The resources and methods to implement those habilitative activities could come from the provider or through the natural supports in the community.

Example - Christine's habilitation plan focuses upon the skills she will need to have a relationship with her friend. The plan may show she will learn to make telephone calls to her friend.

Initially the provider may create opportunities for John to be near animals. The plan may call for him to visit a petting zoo, a household pet may be brought in a few times each week, or someone may help him to buy goldfish. His plan could address the behavior he should exhibit at the petting zoo. John could also be taught to feed the goldfish, yet not put his hands in the water in an attempt to touch it.

3. **The final step requires the habilitation service provider to use professional judgment.** The provider, based on experience and expertise, may recommend some services in addition to those identified by the consumer, advocate, and service coordinator to further support the consumer's outcomes.

Example - The service provider can foresee that Christine and her friend may soon be enjoying community activities with less staff supervision. Therefore, the provider recommends the plan also includes learning how to contact the IRA by phone and how to make a 911 emergency call. John has an extensive history of being taught personal hygiene skills and activities of daily living, none of which have shown noticeable improvement in recent years. The habilitation provider may recommend John only receive the support needed to maintain his current skill levels. The remainder of the plan will focus upon exposing him to everyday experiences with an expectation that staff will discover activities which he may enjoy and will motivate him to learn.

### **Individualizing the Service and the Plan**

People with disabilities are entitled right now, within available resources, to enjoy community living and relationships with family and friends. The habilitation plan should describe what the person will learn **while** he or she pursues an outcome. **People are not required to “earn” a life in the community by first mastering one or more skills.**

The provider, service coordinator, and advocate may not have an extensive understanding of the person's life preferences, usually because the consumer has seldom had the chance to develop relationships or learn about community living. Therefore *the plan may contain activities that expose consumers to new experiences and people in the community solely for the purpose of gaining knowledge* — about their surroundings and about themselves.

Once the habilitation plan is written and implementation begins, staff will learn more about the person and what he or she prefers to experience in life. *As discoveries are made about the person's preferences, new activities should be explored and the habilitation plan may be updated.*

Developing a better understanding about a consumer's preferences, then finding the supports or teaching the skills needed to enjoy those preferences, results in individualized services.

### **Describing the Service Activities**

The description of habilitative activities should be determined by the importance of the activity to the person and the professional judgment of the service provider. Often the activity can be stated in a brief narrative sentence. For example, “Terry will be taught to choose her clothing with proper color combinations that please her.” Yet other parts of the overall service may be so routine that they could be unstated, such as helping a person get on and off a van.

Someone else may be working for a fast-food restaurant which expects staff to dress in a standard uniform. This plan may have a detailed methodology, and possibly data collection as well, to minimize mistakes that might create problems with the employer.

### **Review of the Habilitation Plan**

The service coordinator will review any habilitation plans when needed, but **at least semi-annually**. This review may be done at the time of the ISP review. *Best professional practice suggests the habilitation provider would contribute to any review which could affect the quality of the habilitative (or other) services.*

Service coordinator will review Habilitation Plan when needed, but at least semi-annually.

#### **Information required in the Habilitation Plan:**

- **Identification of service provider.**
- **Effective date(s) of the plan.**
- **The consumer's valued outcomes for receiving habilitation services.**
- **Brief description of the habilitation services that will be provided to attain the consumer's ISP outcomes.**
- **Expected frequency and duration of each service (e.g. daily, six hours/week, for six months, ongoing, etc.).**
- **Beginning date for each service (if different from the effective date of the plan).**
- **Signature and title of the person writing the plan.**

### **Documentation / Service Notes**

Service notes/documentation serve two purposes. One purpose is to provide an audit trail that the services have been delivered in accordance with the habilitation plan. The second purpose is to provide, as part of the ongoing review and revision process of the ISP, information concerning the individual's response to the services.

Frequently used options for creating this audit or "paper trail" include:

**A Statement of Affirmation** which attests that the service was given as described in the ISP and habilitation plan. It must be signed and dated by someone who gave the service or who has knowledge that the service was given by someone else. This may be affixed to an attendance roster of individuals served by that staff person.

OR

**A Checklist** which minimally indicates that services were provided consistent with the plan. It is dated and signed by a person who either gave the service or knew it was provided.

OR

**A Narrative Note** (see below) which also indicates that services were provided consistent with the plan. Thus, service providers may use the format of a narrative note to document both the quality of the service and verify that the service was given. If used in this way, the note is signed and dated by someone who gave the service or who has knowledge that the service was given.

Audit Trail
Basic documentation needs to be available to support service billing. This documentation includes information that: (a) the individual received the service and that (b) the staff person provided the service in accordance with the written habilitation plan -- in the form of signed and dated documentation.

### Guidelines for Narrative Notes

A **narrative note** is an optional method of communicating information about the delivered services. This note, similar to a diary, is *a chronological description of the activity's effect on the consumer's quality of life*. Insightful service notes will contain discoveries that suggest to both the habilitation service provider and the service coordinator changes to be considered in the ISP and therefore also in the habilitation plan. Notes are dated and signed by the person who wrote the note.

What might a narrative note include to describe the quality of the services?

Obstacles that prevent the consumer from benefiting from the activity.

New experiences that the consumer enjoys and which bring a feeling of success.

Recommendations to improve the activity, overcome barriers.

Information that would suggest modifying the valued outcomes in the ISP.

Information that would make the person's services more individualized, help him or her be more independent, improve the chances of being included in community life, or become more productive.

Other occurrences or ideas that you wish to **communicate to the service coordinator**.

*The frequency and extent of the optional narrative notes will be determined by the nature of the service and the individual's response.* For example, if the activity is aimed at assisting an individual to decrease aggressive or self-injurious behaviors, frequent service notes may be needed. Other activities, which may be targeted at more long term change, may need notes less often. Service providers should *exercise their best professional judgment when instructing staff about how often a narrative note should be written.* **Best practices suggest that service notes be entered at least once a month** -- unless professional judgment recommends that notes be made more often.

**Note: Community Residential Habilitation** services provided under the auspices of NYCRR Part 671 (in either state-operated or voluntary-operated community residences) include specific service recording requirements that are set forth in Part 671.6(a)(7) and (8).

## Special Notes

### Families as Providers of Service

At times relatives or friends would like to provide a waiver service, such as residential or day habilitation. On an exception basis the relative or friend may apply to become a provider of service if he or she meets the qualifications. Such instances would be rare because Medicaid funds are not available to pay legally responsible relatives for services which would normally be provided without charge by members of the nuclear family. Questions should be directed to the local DDSO.

### Protective Oversight

An individualized plan of protective oversight is required for anyone who resides in an Individualized Residential Alternative (IRA). **The plan is the responsibility of the agency that operates the IRA.** Most IRAs are administered by the same agency which provides residential habilitation. The individual plan for protective oversight is commonly found with the residential habilitation plan, and should be attached to the consumer's ISP. When developing the individual plan, the IRA operator may draw from the ISP's descriptive information about the consumer that will suggest the fire safety and other possible needs requiring safeguards.

Available guidelines indicate compliance with the regulations NYCRR Part 686.16 (b)(4) and (5) will consider the thoroughness of the plan with regard to the preferences and needs of the individual and the balance between the degree of risk versus protection of the individual. In no case is there any requirement or expectation that the individual plan for protective oversight should address the provision of any habilitation services. **The following components are suggested topics for review only and are not to be construed as a set of requirements and/or mandates:**

Health care needs	Medications
Behavioral needs	Dental care
Nutrition	Personal hygiene
Appropriate, adequate clothing	Freedom from abuse
Adequate supervision in the community	Rights
Need for periodic review of protective oversight	Integration of a plan of protective oversight with other services

### **Day Habilitation - 51% Guideline**

Day Habilitation services are provided “primarily in a non-residential setting separate from the person's home/residence with exceptions allowed to promote transition or adaptation.” The location where the service is given, whether in the home or anywhere outside the residence, should be determined from the outcome(s) which has a value for each consumer. The proportion of time spent at home versus in the community should reflect the person's needs and desires and the philosophy that a person should, whenever possible, receive day services in the community.

As a general guideline, it is expected that at least 51% of a person's day habilitation services should be provided away from the home. This guideline is not a regulatory requirement, nor does it imply an expectation that the service hours in any specific day or week or even month should be counted in order to meet a percentage at any location.

The ISP and day habilitation plan should contain information which explains why any portion of the day service takes place in the home. The ISP and day habilitation plan should be amended if the pattern of service changes. Spending less than 51% of a person's time in the community may be appropriate for the exceptionally medically frail or the elderly, for example. Extreme weather conditions or seasonal physical reactions, such as asthma, may also justify a plan that allows a person to remain in the home at certain times of the year.

*Plans which justify day services occurring in the home should retain a community focus in accordance with the person's interests and abilities.* For such consumers it would be expected that people from the community or community oriented activities could be brought into the home or, if the individual were unable to interact with anyone, that fact would be so noted. A fundamental assumption is that everyone, regardless of age or infirmity, should have an opportunity to receive stimulating activity. Providers should try to find a balance between the person's capacity to benefit from stimulation and the ideal outcome that everyone will be in the mainstream of community life.

The amount of time spent in community related activities should be determined individually. Services should not be scheduled at home for reasons of staff or programmatic convenience or because the person meets an arbitrary criterion such as age group or need for specialized transportation.

### **Transportation**

All transportation associated with HCBS habilitative services (residential, day habilitation, prevocational services or supported employment) is part of the habilitative service and is the responsibility of the pertinent waiver service provider. This includes transportation from the consumer's home to day service.

### **Community Residences and Family Care Homes**

Community Residences, governed by NYCRR Part 671, and Family Care homes have specific regulatory requirements which complement the information found in this section. Consumers and providers associated with those services should also refer to the respective manuals.

### **Cooperation Between Service Providers**

Good professional practice indicates that providers should routinely work cooperatively with one another when it will help the consumer. Specific events related to the consumer's health or behavior that are sudden, excessive, or unusual should also initiate communication between providers. The service coordinator should also be part of such discussions.

# Chapter 9 - RESPITE SERVICES

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Administrative Memorandum - #2005-02, HCBS Respite/Non Waiver  
Enrolled (NWE) Respite Service Documentation Requirements

\*(Memorandum located in the back of this manual)



Jennifer is a ten year old girl, with moderate mental retardation. She enjoys living at home, and Mom and Dad are very supportive of her remaining with them. However, every now and then her parents like to spend a few days alone at a friend's vacation home. Jennifer understands that they sometimes need a short rest away from all the pressures of daily life. They are able to make these plans because Jennifer's service coordinator helped them find a family care home to care for Jennifer while they are away. The family care home is also available for emergencies such as the time Jennifer's Dad required surgery.

## Definitions

Respite is an "indirect" service that provides relief to individuals who are responsible for the primary care and support of consumers. When a family member, Family Care provider, or live-in/house-parent staff has to deal with such things as illness, emergency, and vacation, respite services are intended to ensure that the consumer's basic needs are met.

When someone is using a respite service, consideration must be given to continuing participation in his/her day program and any other activities, in accordance with his/her current wishes and needs.

There are two levels of respite services -- **Basic** and **Skilled**.

**Basic Respite** - Services provided by someone other than a Registered Nurse or Licensed Practical Nurse.

**Skilled Respite** - Services provided by either a Registered Nurse or Licensed Practical Nurse because of the consumer's medical or health condition.

Respite may be provided in two categories -- **Hourly** and **Overnight**.<sup>1</sup>

**Hourly Respite** - This respite may be delivered in a person's home, family care, or OMRDD certified or approved site, with the exception of IRAs. When delivered in the person's home, it may be provided for as many as 24 hours in one day.

**Overnight Respite** - This is referred to as Residential Respite in the Respite Price Setting Guide and is an *overnight* stay in an OMRDD operated, certified, or approved respite site. Locations where the services may be provided are limited to family care homes, guest respite homes, freestanding respite centers, community residences certified under 14NYCRR Part 686 and, under certain circumstances, ICFs in the community. Respite may be provided in existing IRA Temporary Use Beds (TUBs) with the consent of the people living in the IRA.

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<sup>1</sup>See the guide for "Respite Price Setting," available from the OMRDD Bureau of Revenue Support Services, 30 Russell Road, Albany, NY for detailed information on how costs are calculated for these levels and categories of service.

**Guest Respite** - Guest Respite is hourly or overnight respite occurring in a private home in the community that is not a family care home. Guest Respite providers enter into a contract with a DDSO or with a voluntary provider authorized to provide respite services under the waiver. To assure that safety and environmental standards are met, there are certain minimum physical plant requirements that must be complied with. These are contained in the Guest Respite Home Survey, which is included in this chapter.

## Service Standards

All providers of waiver respite should adhere to the following service standards:

- 1) Only agencies with a Medicaid provider agreement which includes waiver respite as an authorized service may receive reimbursement for those services.
- 2) All respite care must be provided by staff of OMRDD, staff of voluntary, not-for-profit human service agencies, family care takers or guest respite providers who are qualified to provide respite care. Any person providing such care must have training or experience which is tailored to the needs of the person who is being cared for, and which is satisfactory to the consumer, advocate/family, and DDSO. The respite provider must be observed and evaluated by a qualified service coordinator or QMRP who will document that the provider is capable of providing the level of respite care needed by the consumer. Records of training and experience and the results of the observation and evaluation will be maintained on file by the provider agency and the DDSO.
- 3) Respite care provided in a community residence and an IRA must comply with 14 NYCRR Part 686.15. These regulations outline the requirements for TUBS beds, including length of stay limitations and the responsibilities of the respite facility. TUBS beds may only be authorized in IRAs of 4 beds or more.
- 4) Respite care provided in freestanding respite centers, guest respite homes, or family care homes must comply with the contractual agreements through which provision of respite services has been authorized.
- 5) Federal financial participation for the cost of room and board is available only when provided at a site approved by OMRDD that is not a private residence.

## Special Notes

**Sitter Services:** Many families have the need for more regularly scheduled substitute supervision and care for the consumer when they need time to pursue educational opportunities, when their work hours do not coincide with the day program hours of the family member, or if there are other circumstances requiring on-going substitute care. *Current respite definitions and guidelines preclude this type of service under the waiver*, and staff at Central Office are exploring ways in which the definition of respite services can be expanded.

**Guest Respite Billing and Reimbursement:** Specific guidelines for guest respite billing and reimbursement need to be established. This is being discussed with Revenue Support.



New York State  
Office of Mental Retardation and  
Developmental Disabilities

**GUEST RESPITE HOME SURVEY  
FOR ONE-AND-TWO FAMILY DWELLINGS**

Inspector \_\_\_\_\_

Guest Respite Applicant Name \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Zip Code \_\_\_\_\_

\_\_\_\_\_ ) \_\_\_\_\_

Telephone Number \_\_\_\_\_

\_\_\_\_\_

Sponsoring Agency \_\_\_\_\_

Have there been changes to the home since the last inspection?

Approximate Age of the Home: \_\_\_\_\_

Gross Square Feet Per Floor:

Basement \_\_\_\_\_ First Floor \_\_\_\_\_ Second \_\_\_\_\_

A. RESPITE SLEEPING SPACES	YES	NO	IF NO, COMMENTS
1. Is there access to each respite 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?			
3. a. Is natural light and ventilation provided in each respite bedroom?  b. Is there an openable window for emergency use in each respite bedroom?			
<b>B. HABITABLE SPACES (Living, Sleeping, Eating or Cooking)</b>			
4. Are all habitable spaces no more than 4'0" below average grade?			
<b>C. NON-HABITABLE SPACES (pantries, toilet, laundry, storage, utility, hallways and stairways, garages)</b>			
5. Are toilet rooms and bathrooms arranged to provide privacy?			
<b>D. ALL SPACES</b>			
<b>Electrical</b>			
6. Are wires free from fraying or insulation cracking?			
7. Are there enough outlets to prevent makeshift wiring and use of extension cords?			

Heating, Ventilating, Air Conditioning and Fuel Storage	YES	NO	IF NO, COMMENTS
<p>a. Is heating equipment and fuel storage safe and operable?</p> <p>b. If a wood stove/fireplace exists, is it maintained in a safe manner?</p> <p>c. Are there no portable space heaters (except for emergency use)?</p> <p>d. Do portable fire extinguishers meet NFPA 10 and are UL approved and labeled?</p> <p>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.</p>			
<b>Stairs</b>			
10. Do stairways have a handrail on at least one side?			
11. a. Are smoke detectors installed in each corridor adjacent to sleeping rooms?			
b. Is at least one smoke detector installed at the head of the basement stairs?			
<b>Environmental</b>			
12. Are general plumbing systems safe, sanitary and in serviceable condition?			
13. Is dwelling free of obvious safety hazards?			
14. Does the home have telephone service?			
<b>Exterior Property</b>			
15. If there is a 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).			
16. Are grounds free of obvious safety hazards?			
<p>17. 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):</p> <p>Environmental testing for lead paint:</p> <p>Safety measures such as anti-scalding devices, electrical ground fault interrupters (gfi), and provisions against consumers locking themselves in rooms.</p>			
<b>Mobile Homes</b>			
18. 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 (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 applicant provide a copy of the occupancy certification certifying compliance with NYS UFPBC Part 1223 Installation Procedures?			
<b>E. Other Issues</b>	<b>Comments</b>		

**Date** \_\_\_\_\_ **Name/Address** \_\_\_\_\_

**GENERAL COMMENTS:**

<p><b>Inspected by:</b> _____</p> <p>_____</p> <p style="text-align: center;"><b>Signature</b></p> <p style="text-align: right;"><b>Date</b></p>
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# Chapter 10 - ENVIRONMENTAL MODIFICATIONS

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Environmental Modification and Adaptive Devices (May 20, 2005)	
*(Memorandum located in the back of this manual)	



**Mary Beth is a woman in her forties who requires a wheelchair for mobility because she has cerebral palsy and epilepsy. She was able to live at home with the help of her Mom and Dad until she suffered a stroke. The stroke coincided with the death of her father. At that time, Mary Beth was placed in a nursing home because her mother could no longer care for her without assistance. Environmental modifications to the first floor of her mother's home, including changes to the bathroom to make it wheelchair accessible have allowed her to return home. Mary Beth can now navigate about her house with greater ease. She is comfortable and contented to be back in a familiar, loving environment.**

## **Definition**

**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.*

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 environment. There are also technologies needed by people who have behavioral or sensory deficits to assure safety at home, and this chapter lists items related to those kinds of deficits. Also please note that to be consistent with federal terminology the term "assistive technology" is used to categorize both environmental modifications and adaptive devices. See "Terminology" Special Note.

This chapter focuses on the approval and procurement of environmental modifications. *However, services may also be provided to assist people in the selection, acquisition, and use of these modifications.* The person's needs, the actual work that must be done, and the ongoing support required to help the person use this "service" are three primary factors that must be considered. The service coordinator and consumer may need to obtain professional expertise for a clinical assessment of the need. They may require the further expertise of architects, contractors, environmental modification specialists, and perhaps therapy specialists in constructing and using the modification.

## Allowable Environmental Modifications

Modifications to address a person's **physical** disabilities, allowing more safe and improved access and/or functioning within the home environment, including:

- Ramps.
  - Lifts (hydraulic, manual, or electrical) for porch, stairs, and/or bathroom.
  - Widened doorways/hallways.
  - Hand railings/grab bars.
  - Automatic or manual door openers/door bells that are required as part of a residential habilitation service plan.
- Bathroom/kitchen modifications or adjustments, such as:
- Roll-in showers.
  - Sinks/tubs.
  - Water faucet controls.
  - Plumbing adaptations (cut-outs, toilet/sink adaptations).
  - Turnaround space changes/adaptations.
  - Worktables/work surfaces adaptations.
  - Cabinet/shelving adaptations.
  - Shatter-proof bathroom/shower doors.

Modifications that address a person's **sensory deficits**, facilitating a more safe environment, including:

- Braille identification systems.
- Tactile orientation systems.
- Bed shaker alarm devices.
- Strobe light smoke detection and alarm devices.

Modifications that promote a more safe environment for people with **challenging behaviors**, including:

- Window protection.
- Reinforcement of walls.
- Durable wall finishes.
- Open-door signal devices.

**Other adaptations including:**

- Medically necessary heating/cooling adaptations as required as part of a residential habilitation services plan or medical treatment. (Any such adaptations utilized solely to improve a person's living environment are to be included as part of room and board costs and not considered E-Mods.)
- Electrical wiring to accommodate other adaptations or equipment installation.
- Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the person's welfare.
- Other appropriate environmental modifications, adaptations, or repairs necessary to make the living arrangement suitable for the person.

## **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.

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. Materials for a ramp, for example, could be provided by a potential employer, and the labor for installation might be donated by a business or civic organization. The use of natural supports in the community is limited only by the resourcefulness and imagination of consumers, advocates, and service coordinators.

In addition to natural supports, generic services and other resources such as State Plan Medicaid and VESID should be used to the greatest extent possible to obtain assistive technology services before accessing the waiver. See the "Other State Agencies As Resources" Special Note.
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## **Special Notes**

**Terminology** - Assistive Technology Services are any services that directly assist a person with a disability in the selection, acquisition, or use of an assistive technology. Assistive technology modifications and devices are adaptations, items or pieces of equipment that can help a person live independently in the home of his or her choice, with the maximum possible control over their activities within the home and in the community. *Environmental modifications* constitute one category of assistive technology. (See also *Adaptive Devices*.)

**Allowable Items** - Most of the environmental modifications that are listed in this section are specifically listed in the waiver agreement with HCFA. However, *this is not an all-inclusive list*. Additional items with a similar purpose, or not yet invented, may fit within the definition of items that could be funded through the waiver.

**Unrelated Construction** - HCBS environmental modifications may not be used to underwrite construction costs unless those costs are clearly tied to the items or modifications that are being provided to improve access and self-reliance. Modifications may not alter the existing "footprint" of the home. (See Home Additions below.)

**One-Time-Only Exceptions** - Environmental modifications are expected to be provided for the most part on a one-time-only basis **per person**. Exceptions must be approved by the DDSO. Approval may be granted if movement to a new residence occurs because of circumstances related to the consumer's health, welfare or safety, or other situations beyond the consumer's control. Exceptions may also be granted in circumstances where the person lives alternately in separate parental residences.

**Replacements** - 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.

**Eligible Providers** - Voluntary agencies and DDSOs can be authorized to provide E-Mods under the HCBS waiver. It is the decision of these providers whether to do the actual work themselves or contract out for the work.

**Residence Type** - HCBS environmental modifications can be made only in a person's home, a community residence, a family care home, or an Individualized Residential Alternative. *If the applicant has been deemed eligible, but currently lives in an ICF/MR or other long term care setting, the modifications may be completed prior to the individual's relocation to the new home.* The timing must be planned so that no more than 30 days passes between completion of work and the person's moving into the home.

**Building Codes/Zoning Laws** - *Providers of environmental modifications must ensure that their work meets the requirements of the New York State Uniform Fire Prevention and Building Code (or the Building Code Of The City Of New York) for conversions, alterations, additions, and repairs to existing buildings.* If the property is non-state owned or operated, the providers of the modifications must ensure that their work also meets the requirements of local building codes and zoning laws.

**Annual Dollar Limit** - OMRDD has established funding ceilings per individual for environmental modifications. For people enrolled in the HCBS Waiver, the State share ceiling is **\$7000 per fiscal year** which, when combined with the federal share of \$7000, yields a **\$14,000** available gross annual amount. 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. The \$7000 OMRDD State share ceiling does **not** apply to adaptive devices.

person/year. The \$7000 OMRDD State share ceiling does **not** apply to adaptive devices.

**Home Additions** - OMRDD has also established a policy that prohibits funding of additions for non-certified homes. A home addition is defined as 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. Families who finance home additions from private sources may seek OMRDD funding assistance, within the limits established by this policy, for specific environmental modifications that are necessary to make the addition meet the needs of the person with a developmental disability.

**Expertise Available to the Consumer** - Professional staff are available to the consumer, 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 consumer are taken into account. These staff include:

- DDSO Community Development Housing Office staff, Plant Superintendents, and/or Safety Officers.
- Clinical staff such as OTs and PTs.
- OMRDD architects.
- Local architects (expect a fee to be charged).
- Independent Living Centers.
- Colleges and universities.

## **Other State Agencies as Resources for Environmental Modifications**

New York State Department of Education; Vocational and Education Services  
for Individuals with Disabilities (VESID); 518-486-4609

New York State Department of Education; Special Education Services  
Contact local school district or:  
The Technology Resources for Education Center (TRE); 518-456-9290

The NYS Office of Advocate for Persons with Disabilities;  
Technology Related Assistance for Individuals with Disabilities (TRAID) project  
Regional TRAIID centers; 1-800-522-4369

New York State Commission for the Blind and Visually Handicapped (CBVH)  
Contact the Albany office (518-432-2789) re:  
Assistive Technology Resources Centers

New York State Department of Health; Early Intervention Program for Infants and  
Toddlers Contact local health department, local school district or:  
Early Intervention office in Albany; 518-473-7016.

New York State Department of Health; Physically Handicapped Children's Program  
Contact local county health department.

New York State Commission on Quality of Care for the Mentally Disabled (CQC);  
Client Assistance Program (CAP) 518-473-7378  
Protection and Advocacy Services for the Developmentally Disabled (PADD)

## Steps to Approval of Environmental Modifications

- 1 - As part of developing the PISP/ISP, the applicant, the advocate, and the 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.
- 2 - If it is determined during this early stage in the process that the applicant needs an environmental modification, the applicant, advocate, and service coordinator decide whether payment for the environmental modification is available through informal community supports and resources, the Medicaid State Plan, or federal/state agencies other than OMRDD. *These funding sources must be accessed first, if available*, with the service coordinator assisting the consumer in making contact with those agencies.
- 3 - 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.
- 4 - 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 an IRA, FC, CR, or own home.

If renovations/construction work will be needed in the home, information about the ownership of residence in which the individual lives and, if rented, who the landlord is. The consumer/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.

- 5 - The enrolled participant, with the advocate and service coordinator, proceeds with the steps of the **procurement process** outlined according to where the consumer lives...

In Own Home or in Family Care (pp. 10-7 - 10-9)

In a Voluntary Operated IRA or CR (pp. 10-10 - 10-11)

In a State Operated IRA or CR (pp. 10-12)

## Environmental Modifications Procurement Process for: People Living at Home and in Family Care

Funds for environmental modifications come from a 100% capital appropriation.

After the consumer, 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:

1. As is noted in Step 4 of the Steps to Approval, the service coordinator will assist the consumer, 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.

**Medicaid is always the payor of last resort.** The family care provider, consumer, 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 should be contacted, before going to bid, to review the plans. Any work done in a family care home must conform with family care certification requirements. The service coordinator should be prepared to assist the consumer, advocate, or family care provider throughout this process.

2. The family care provider, consumer, or advocate will contact the vendors (craftsmen) of environmental modification services and document price quotes or bids as specified below. The consumer 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.
3. The consumer, advocate, or family care provider, with assistance from the 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:
  - a. Up to \$5,000, selects a reliable vendor (taking steps necessary to ensure reasonable pricing) and obtains a written quotation from the selected vendor which includes all terms and conditions of sale.
  - b. Above \$5,000, solicits a minimum of three comparable written bids when sufficient vendors are available.

4. If the consumer 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 which cannot be billed to Medicaid.**
5. When the estimates or bids have been obtained, the consumer, 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.
6. The DDSO or voluntary provider reviews the information to ensure adherence to the standards and definitions in the HCBS Provider Guide.
7. The DDSO will send written approval and a copy of the proposed contract, or disapproval of the proposed environmental modifications to the consumer/advocate, family care provider or the voluntary agency, and the service coordinator. Disapproval notices must include reasons for the decision.
  - a. Working through the DDSO: The family care provider or consumer/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 form EM-1A 1/93, and submit it to the Bureau of Cost and Revenue Development 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 consumer based on lowest reasonable bid. The voluntary agency provides reimbursement, in turn, to the family care provider or consumer/advocate. The contract - available from the DDSO - should be used by any party (family care provider, consumer/advocate, or voluntary agency) seeking reimbursement directly from OMRDD.

**At a future time, voluntary providers will be able to bill Medicaid directly for these services.**

8. Contracts, once signed, must be returned to the DDSO by the consumer, advocate, family care provider, or voluntary agency.
  - a. Contracts under \$10,000 are fully executed upon signing by the DDSO director and should be submitted to Budget and Fiscal Services (Central Office) for processing.
  - b. Contracts of \$10,000 or more must follow standard contract processing procedures. These contracts are fully executed upon approval by the Office of the State Comptroller.
9. The family care provider, consumer, 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 (EM HCBS 11/92) and submitted by the DDSO to OMRDD Bureau of Community Funding 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. This will speed up the payment process for some expenses.

Note: At the time of this printing, HCFA had just approved a technical amendment that will allow FFP for environmental modifications obtained directly by families or consumers through vouchers. The Division of Revenue Support will be issuing instructions which will include the use of a new authorization form.

***FOR MORE DETAILED INFORMATION AND COPIES OF FORMS,***

***CONTACT YOUR DDSO.***

## Environmental Modifications Procurement Process for: People Living in Voluntary Operated IRAs and CRs

Funds for environmental modifications come from a 100% capital appropriation.

After the consumer, advocate, and service coordinator have completed the appropriate Steps to Approval, the following steps are necessary to obtain environmental modifications and arrange for payment:

1. For VOIRA and VOCR sites when no other rehabilitation/construction is required, the service coordinator contacts the HCBS Waiver or CSP coordinator at the DDSO. This staff person will determine what CSP funds are available and explain the procedures for securing them, including obtaining landlord approval in rental situations.

**Medicaid is always the payor of last resort.** The provider of services is obligated to first bill alternative coverage for environmental modifications before billing Medicaid.

The provider solicits bids for environmental modifications good for a minimum of 180 days, as follows:

- a. Up to \$5,000, selects a reliable vendor (taking steps necessary to ensure reasonable pricing) and obtains a written quotation from the selected vendor which includes all terms and conditions of sale.
  - b. Above \$5,000, solicits a minimum of three comparable written bids when sufficient vendors are available.
2. In VOIRA and VOCR sites where construction/renovation above and beyond environmental modification is required, the scope of work for the environment modification should be included in the overall construction/renovation specifications for bidding but separately identified.
  3. When the estimates/bids have been obtained, the provider sends the DDSO the written estimates/bids, name of the selected vendor, and the reason for selecting that vendor. A copy will also be sent to the service coordinator by the provider.
  4. The DDSO reviews the information for adherence to standards in the HCBS Provider Guide.
  5. The DDSO sends written approval and a copy of the proposed contract, or disapproval of the proposed environmental modification, to the service coordinator and provider. Disapproval notices must include reasons for the decision.
  6. Signed contracts must be returned to the DDSO by the provider.
    - a. Contracts under \$10,000 are fully executed upon signing by the DDSO director and should be submitted to Budget and Fiscal Services for processing.

- b. Contracts of \$10,000 or more must follow standard contract processing procedures. These contracts are fully executed upon approval by the Office of the State Comptroller.

Copies of fully executed contracts must be sent to the provider by the DDSO.

7. The provider can claim reimbursement by submitting a New York State Standard Voucher (AC 92) 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 must be attached to substantiating documentation in a form prescribed by the DDSO (EM HCBS 11/92) and submitted by the DDSO to the OMRDD's Bureau of Community Funding for processing. For VOIRAs and VOCRs which will be MCFFA bonded, a copy of the substantiating documentation must also be submitted to OMRDD's Capital Financing Services.

***FOR MORE DETAILED INFORMATION AND FORMS,  
CONTACT YOUR DDSO.***

**Environmental Modifications Procurement Process for:  
People Living in State Operated IRAs and CRs**

**The Activity Reporting Manual, prepared by the Bureau of Cost and Revenue Development, contains detailed instructions for obtaining reimbursement for HCBS environmental modifications. Contact the DDSO for copies of this manual and for required forms that are referred to below.**

After the consumer, advocate, and service coordinator have completed the appropriate Steps to Approval, the following steps are necessary to obtain the service and arrange for payment:

1. The service coordinator will contact the DDSO, which will be the provider of service for people in SOIRAs and SOCRs, to request environmental modification services. Funds for the services will come from a capital allocation identified by OMRDD's central office Budget Office.

**Medicaid is always the payor of last resort.** The provider of services is obligated to first bill alternative coverage for environmental modifications before billing Medicaid.

2. The DDSO staff designated to handle HCBS contracts and purchasing will follow established OMRDD procedures for contracting out when a private vendor is chosen to provide environmental modification services. Those costs must be reported on the State Operated Environmental Modifications Reporting Form (EM-1). If the DDSO chooses to use their own staff to complete the environmental modifications, they must record the personal service and construction supply costs on the State Operated Environmental Modifications Reporting Form.
3. In SOIRA and SOCR sites where construction/renovation other than environmental modifications are required, the scope of work for the environmental modification should be included in the overall construction/renovation specifications but identified separately.



# Chapter 11 - ADAPTIVE DEVICES

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Environmental Modifications and Adaptive Devices (May 20, 2005)	
*(Memorandum located in the back of this manual)	



Joseph is a 30 year old man who experienced a traumatic brain injury. He has lived in a variety of institutions during his lifetime but now enjoys living independently in a one person IRA. Along with his new home, he has been equipped with an electronic communication device known as a "liberator." The device is attached to his wheelchair, and he only has to strike the keyboard with a pointer to communicate with friends, family and colleagues. It has enabled Joseph to socialize and become more involved in his community. Despite his speech difficulties, the liberator has offered Joseph the opportunity to lead a more satisfying and happy life.

## Definition

Adaptive devices are aids, controls, appliances, or supplies - of either a communication or adaptive type - which 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, we use the term "assistive technology" to categorize both environmental modifications and adaptive devices. The term used for adaptive devices in the previous edition of this guide was "adaptive technologies."

This chapter focuses on adaptive devices that are allowable under the HCBS waiver and the basic approval and procurement processes. *However, services may also be provided to assist people in the selection, acquisition and use of adaptive devices.* Consumers and service coordinators must know where to obtain expertise to assess the disabled person's needs for adaptive devices and determine what devices would be most appropriate for the person (e.g., through input from clinicians and rehabilitation engineers). They must also provide ongoing support to help the person make best possible use of the adaptive device and periodically reassess the effectiveness of the device as it relates to the person's changing needs and capabilities and new technology that may be available. The individualized service plan should reflect the provision of these assistive technology services and 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.

## Allowable Adaptive Devices

Communication aids and devices, including:

- Personal emergency response systems which 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 DSS regulations and administered by the county.*
- Augmentative Communication Devices\* such as:  
Direct selection, alpha-numeric, scanning, and encoding communicators.  
Speech amplifiers.  
Electronic speech aids/devices.
- Voice, light or motion activated electronic devices.\*

Adaptive aids and devices including:

- Standing boards/frames.\*
- Adaptive switches/devices.\*
- Feeding, dining, and meal preparation aids/devices/ appliances.\*
- Specially adapted locks.
- Motorized wheelchairs.\*
- Guide dogs and similar trained animals.
- 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, wheelchair and individual restraint systems, electrical safety interlock devices for lifts (transmission, ignition, etc.), stretcher stations (restraints, tautens), structural vehicle modifications (door height, door width, interior headroom, roof height, etc.), interior grab bars, skid-resistant floor coverings, exterior and interior lighting, and flip seating for ambulatory passengers who may be accompanying the person.
- Computer hardware and software that are used to assist a person with improving communication and/or adaptive skills.
- Adaptive aids and devices, other than the above, that would not otherwise be covered by the State Medicaid Plan.

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\* See page 11-3 for additional information.

Custom-fitting and maintenance and repairs to such adaptive devices (i.e. equipment) which are cost-effective are also allowable.\* It is the service coordinator's responsibility, along with input from clinical or other qualified professional staff when appropriate, to determine the cost-effectiveness of such repairs and maintenance. Payment for an assessment of the need for an adaptive device; for helping select a particular device; or for training in the use of a device may be sought through state plan Medicaid or waiver habilitation services funding.

*\*These devices/services may be covered services under the Medicaid state plan in the category of durable medical equipment (DME). A physician's prescription for the adaptive technology is required. The item must then be acquired through an approved Medicaid vendor who submits a claim to the District MMIS Office. To get the address and phone number of your District MMIS Office, contact the MMIS Office in Albany at (518)474-8161.*

## **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.

Fund-raising activities 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 a particular item. A van lift could be acquired through a fund drive. Labor for installation could be donated by a civic organization. The use of natural supports is limited only by the resourcefulness and imagination of consumers and the advocates and service coordinators who are working with them.

In addition to natural supports, generic services and other funding resources should be used to the greatest extent possible to obtain assistive technology services before accessing the waiver. This would include resources such as State Plan Medicaid, programs administered by the NYS Department of Education (e.g. VESID and Special Education Services), the NYS Commission for the Blind and Visually Handicapped (CBVH), and programs administered by the NYS Department of Health (Early Intervention and Physically Handicapped Children's Program).

## **Special Notes**

**Terminology** - *Assistive Technology Services* are any services that directly assist a person with a disability in the selection, acquisition, or use of an assistive technology. Assistive technology modifications and devices are adaptations, items or pieces of equipment that can help a person live independently in the home of his or her choice, with the maximum possible control over their activities within the home and in the community. *Adaptive Devices* constitute one category of assistive technology that may be funded through the HCBS Waiver (See also *Environmental Modifications*).

**Allowable Items** - The particular adaptive devices that are listed in this section are those which are specifically listed in the waiver agreement with HCFA. This is not an all-inclusive list, because additional items not yet proposed, or perhaps not yet invented, may fit within the definition of what may be funded through the waiver.

**Billing** - For billing purposes, the units of service for adaptive devices consist of one approved communication or adaptive piece of equipment as specified in the person's individualized service plan. A person may, based on need, receive more than one unit of service. Only those adaptive devices not reimbursable as Durable Medical Equipment under State Plan Medicaid will be reimbursable under the waiver.

**Replacements** - Items that have 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.

**UL/FCC Approval** - *Providers of adaptive devices must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC Regulations, as appropriate.*

**Dollar Limit** - The State share funding ceiling that OMRDD established for environmental modifications funded through the HCBS waiver, does **not** apply to adaptive devices.

**Expertise Available to the Consumer** - Occupational Therapists, Physical Therapists and Speech-Language Pathologists may be trained to assess the needs for adaptive devices. They are also able to help access resources such as the Board of Cooperative Educational Services (BOCES); Technology Resources for Education (TRE); Independent Living Centers (ILC), the Technology Related Assistance for Individuals with Disabilities (TRAID) program sponsored by the NYS Office of Advocate for Persons with Disabilities; and colleges and universities. These resources are available to support the activities of the service coordinator, consumer, and advocate from the time of identifying the need for an adaptive technology through its successful acquisition and use.

## Other State Agencies As Resources

New York State Department of Education; Vocational and Education Services  
for Individuals with Disabilities (VESID); 518-486-4609

New York State Department of Education; Special Education Services  
Contact local school district or:  
The Technology Resources for Education Center (TRE); 518-456-9290

The NYS Office of Advocate for Persons with Disabilities;  
Technology Related Assistance for Individuals with Disabilities (TRAID) project  
Regional TRAIID centers; 1-800-522-4369

New York State Commission for the Blind and Visually Handicapped (CBVH)  
Contact the Albany office (518-432-2789) re: Assistive Technology Resources Centers

New York State Department of Health; Early Intervention Program for Infants and  
Toddlers Contact local health department, local school district or:  
Early Intervention office in Albany; 518-473-7016.

New York State Department of Health; Physically Handicapped Children's Program  
Contact local county health department.

New York State Commission on Quality of Care for the Mentally Disabled (CQC);  
Client Assistance Program (CAP) 518-473-7378  
Protection and Advocacy Services for the Developmentally Disabled (PADD)

## Steps to Approval of Adaptive Devices

- 1 - As part of developing the PISP/ISP, the applicant, the advocate, the service coordinator (and assistive technology expert such as clinician as appropriate) determine what, if any, adaptive device is needed. Evaluations by clinicians and other professionals who are familiar with assistive technology services should be completed as appropriate.
- 2 - If it is determined during this early stage in the process 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 and resources, the Medicaid State Plan, or federal/state agencies other than OMRDD. *These funding sources must be accessed first, if available*, with the service coordinator assisting the consumer in making contact with those agencies.
- 3 - 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.

- 4 - As part of the DDSO review of the PISP/ISP, the DDSO representative 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:

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 an IRA, CR, FC, or own home.

When the acquisition of a particular adaptive technology is expected to involve installation in the home, information about ownership of the residence in which the individual lives, and, if rented, who the landlord is. The consumer/advocate, with the assistance of the service coordinator or DDSO representative as needed, must obtain the owner's approval for the installation, 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.

- 5 - The enrolled participant, with the advocate and service coordinator, proceed with the steps of the **procurement process** according to where the consumer lives.

People Living At Home or in Family Care (pp. 11-7 - 11-8)

People Living a Voluntary Operated IRAs and CRs (pp. 11-9 - 11-10)

In a State Operated IRA or CR (pp. 11-11)

## **Adaptive Devices Procurement Process for: People Living at Home and in Family Care**

**Funds for adaptive devices come from a 100% capital appropriation.**

After the consumer, 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:

1. As is noted in Step 4 of the Steps to Approval, the service coordinator will assist the consumer, 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.

**Medicaid is always the payor of last resort.** The family care provider, consumer, or consumer's family is obligated to first bill alternative coverage, such as private health insurance covering adaptive devices, before billing Medicaid under the HCBS waiver.

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 with family care certification requirements.

2. The family care provider, consumer, 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.
3. The consumer, 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:
  - a. Up to \$5,000, selects a reliable vendor (taking steps necessary to ensure reasonable pricing) and obtains a written quotation from the selected vendor which includes all terms and conditions of sale.
  - b. Above \$5,000, solicits a minimum of three comparable written bids when sufficient vendors are available.
4. When the quotes or bids have been obtained, the consumer, advocate or family care provider sends the DDSO or the voluntary provider, who is an approved provider of adaptive devices, the written quotes or bids and name of the lowest responsible bidder.

Voluntary agencies must notify the DDSO of the quotes or bids and the chosen vendor. The service coordinator should be available to provide any needed assistance and should be notified when this information is submitted.

5. The DDSO or voluntary provider reviews the information for adherence to standards and definitions in the HCBS Provider Guide.

6. The DDSO will send written approval and a copy of the proposed contract, or disapproval of the proposed adaptive devices, to the consumer/advocate, family care provider or the voluntary agency, and the service coordinator. Disapproval notices must include reasons for the decision.
  - a. Working directly with the DDSO: The family care provider, consumer, or consumer's family 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 form APT-1A 1/93, and submit it to the OMRDD Bureau of Cost and Revenue Development 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 consumer based on lowest reasonable bid. The voluntary agency provides reimbursement, in turn, to the family care provider, consumer, or consumer's family. The contract - available from the DDSO - should be used by any party (family care provider, consumer/advocate, or voluntary agency) seeking reimbursement directly from OMRDD.

**At a future time, voluntary providers will be able to bill Medicaid directly for these services.**

7. Contracts, once signed, must be returned to the DDSO by the consumer, advocate, family care provider, or voluntary agency.
  - a. Contracts under \$10,000 are fully executed upon signing by the DDSO director and should be submitted to Budget and Fiscal Services (Central Office) for processing.
  - b. Contracts of \$10,000 or more must follow standard contract processing procedures. These contracts are fully executed upon approval by the Office of the State Comptroller.
8. The family care provider, consumer, consumer'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 (AT HCBS 1/93) and submitted by the DDSO to the OMRDD Bureau of Community Funding 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.

<b><i>FOR MORE DETAILED INFORMATION AND FORMS,</i></b>
<b><i>CONTACT YOUR DDSO</i></b>

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## Adaptive Devices Procurement Process for: People Living in Voluntary Operated IRAs and CRs

Funds for adaptive devices come from a 100% capital appropriation.

After the consumer, advocate, and service coordinator have completed the appropriate Steps to Approval, the following steps are necessary to obtain the adaptive device and arrange for payment:

1. The service coordinator contacts the HCBS waiver or CSP coordinator at the DDSO who will ensure that funds are available and explain the process to secure them, including obtaining landlord approval in rental situations.

**Medicaid is always the payor of last resort.** The provider of services is obligated to first bill alternative coverage for the adaptive device, before billing Medicaid.

The provider solicits bids for the adaptive device, good for a minimum of 180 days, as follows:

- a. Up to \$5,000, selects a reliable vendor (taking steps necessary to ensure reasonable pricing) and obtains from the vendor a written quotation that includes all terms and conditions of sale.
  - b. Above \$5,000, solicits a minimum of three comparable bids when sufficient vendors are available.
2. When the estimates/bids have been obtained, the provider sends the DDSO the written estimates/bids, name of the selected vendor, and the reason for selecting that vendor. A copy will also be sent to the service coordinator by the provider.
  3. The DDSO reviews the information for adherence to standards in the HCBS Provider Guide.
  4. The DDSO sends written approval and a copy of the proposed contract, or disapproval of the adaptive device to the service coordinator and provider. Disapproval notices must include reasons for the decision.
  5. Signed contracts must be returned to the DDSO by the provider.
    - a. Contracts under \$10,000 are fully executed upon signing by the DDSO director and should be submitted to Budget and Fiscal Services for processing.
    - b. Contracts of \$10,000 or more must follow standard contract processing procedures. These contracts are fully executed upon approval by the Office of the State Comptroller.

Copies of fully executed contracts must be sent to the provider by the DDSO.

6. The provider can claim reimbursement by submitting a New York State Standard Voucher (AC 92) 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 must be attached to substantiating documentation in a form prescribed by the DDSO (AT HCBS 11/92) and submitted by the DDSO to the OMRDD Bureau of Community Funding for processing.

**FOR MORE DETAILED INFORMATION AND FORMS,**

**CONTACT YOUR DDSO**

#### **Adaptive Devices Procurement Process for: People Living in State Operated IRAs and CRs**

**The Activity Reporting Manual, prepared by the Bureau of Cost and Revenue Development, contains detailed instructions for obtaining reimbursement for HCBS adaptive devices. Contact your DDSO for copies of this manual and for required forms that are referred to below.**

After the consumer, advocate, and service coordinator have completed the appropriate Steps to Approval, the following steps are necessary to obtain the adaptive device and arrange for payment:

1. The service coordinator will contact the DDSO, which will be the provider of service for people in SOIRAs and SOCRs, to request the adaptive device(s). Funds for the services will come from a capital allocation identified by OMRDD central office.

**Medicaid is always the payor of last resort.** The provider of services is obligated to first bill alternative coverage for the service, before billing Medicaid.

2. Adaptive devices will be purchased according to established OMRDD procedures pertaining to supplies and equipment. See the **OMRDD Activity Reporting Manual.**

# Chapter 12 - BECOMING A PROVIDER

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## Who May Be a Provider of HCBS Waiver Services

Any incorporated not-for-profit agency or governmental entity may apply to be a provider. Individuals interested in becoming an authorized provider must obtain not-for-profit status. Evidence of a certificate of incorporation will be required.

A for-profit agency cannot obtain a Medicaid Provider Agreement to deliver HCBS waiver services. There are special circumstances under which a “for-profit” may deliver HCBS services under contract with an agency or governmental entity that has such a Provider Agreement (HCBS Form 12.02.97). See Special Notes.

## Steps to Becoming a Provider

1. Interested Agency Contacts DDSO
  - a. DDSO informs prospective providers about the kinds of documentation that will be required to determine the character and competence of the agency or individual practitioner seeking to provide waiver services.
  - b. DDSO distributes required forms on request.
2. Prospective Provider of Waiver Services
  - a. Submits a letter indicating the intent to become a provider of waiver services, listing the specific services for which provider authorization is being sought. The applicant’s FEDERAL ID # should be included with this letter of intent. (In the absence of a Federal ID #, contact the DDSO Director for guidance.)
  - b. Along with the letter of intent, includes the following:
    - Information regarding the agency’s character and competence.
    - A completed Disclosure of Ownership and Control, HCFA 1513 (HCBS Form 12.01.97). (Be sure that a list of the **Board of Directors** is attached to this form.) *The actual physical location of the agency must be indicated in terms of a street address on the form, even if the mailing address does not include a street or road.*
    - A signed and dated Provider Agreement.
  - c. Submits these documents to the DDSO Director with appropriate original signatures.

3. DDSO Review and Approval

- a. DDSO staff review the documents and recommend approval or disapproval of the application to the DDSO Director.
- b. For applications recommended for approval, the Director completes and signs the Waiver Provider Approval form (HCBS Form 12.03.97) , entering **Effective Dates** which indicate the earliest date when approved services can be delivered.
- c. DDSO staff transmit entire packet to the Division of Quality Assurance - making sure to send the **original** signed Provider Agreement. *In New York City, the DDSO forwards the completed packet to the New York City Regional Office for transmission to the Division of Quality Assurance.*
- d. For applications not approved, DDSO either explains reasons for denial in a letter or requests additional information for further consideration of the application.

4. Division of Quality Assurance (OMRDD)

Reviews the application packet for completeness and appropriate signatures. Then, in writing, requests formal issuance of the Provider Agreement by the **New York State Department of Health (DOH)**.

5. Department of Health

Conducts final review of the application packet.

Transmits finalized agreement to the provider, with copies to the DDSO Director, the Division of Quality Assurance, and the Fiscal Reporting Standards Unit of OMRDD Revenue Management.

## Special Notes

### Operational Standards

All providers must comply with the terms of the Provider Agreement. Until further notice, all potential providers should be given the HCBS Form 12.02.97 for submission to **DOH**.

Providers of Service Coordination, Respite, and all types of Habilitation Services must also operate in accordance with Parts 624, 633, 635, and 636, 686 and 671 of 14 NYCRR.

Providers of Environmental Modification services must ensure that their work meets the requirements of the NYS Uniform Fire Prevention and Building Code, Subchapter E (conversions, alterations, additions, and repairs to existing buildings); and local building codes if the property is not state-owned or operated.

Providers of Adaptive Devices services must ensure that all devices and supplies have been examined and/or tested *as required* by Underwriters Laboratory (or other appropriate organization) and comply with FCC Regulations, as appropriate.

### Character and Competence

The DDSO is responsible for making a judgment about the prospective provider's "character and competence" to deliver services within a given DDSO. That is, DDSO staff must obtain reasonable assurance that the applying agency or individual practitioner is capable of delivering services in accordance with the operational standards. *Signature of the DDSO Director* on the Waiver Provider Approval will be a valid indication that this assurance has been obtained.

Each DDSO will keep written documentation of the provider's "character and competence" on file and available for review.

### Service Certification

Issuance of a Provider Agreement constitutes certification of the covered services. It does not constitute a blanket commitment to sponsor unlimited services.

### Qualifying Standards

**Licensure/certification** requirements apply only in the following circumstances:

1. If clinicians are employed in their professional disciplines by residential habilitation or day habilitation providers, these clinical staff must have appropriate State Education Department licensure or work under the direction of such licensed personnel.

2. When waiver respite is provided outside of the individual's home, the site where the service is provided must meet applicable certification or authorization requirements as follows:

Community Residence and IRA	Parts 686 & 671 (14NYCRR)
Family Care	Part 687 (14NYCRR)
ICF	Part 681 (14NYCRR)
Freestanding Respite Center	OMRDD Contract
Guest Respite Home	DDSO Authorization

### **Contracting With “For Profits” for Delivery of HCBS Services: Organized Health Care Delivery Systems (OHCDS)**

The Office of Mental Retardation and Developmental Disabilities' (OMRDD) Home and Community Based Services (HCBS) waiver is a Medicaid funded program governed by Section 1915(c) of the Social Security Act. The Act also requires a) payment be made directly to the provider of any Medicaid service, and b) a written agreement exists between the single state medicaid agency (New York State Department of Health) and each provider of service. OMRDD requires provider agencies, who participate in the HCBS waiver, to comply with all pertinent sections of the Social Security Act, including those cited above.

There is, however, an exception to the general rule that all providers of HCBS waiver services hold a provider agreement with the single state agency. The Social Security Act also recognizes the Organized Health Care Delivery System (OHCDS) as an entity which is not limited to furnishing services through its own employees. By satisfying the conditions listed below, an OHCDS may contract with other qualified providers to furnish HCBS waiver services. Developmental Disabilities Services Offices (DDSOs) may find that designating a specific provider agency as an OHCDS will allow the flexibility needed to make some service plans more economical or ensure better continuity of services.

*Because of the close Federal scrutiny of payments for allowable Medicaid services, it is recommended that a DDSO use the OHCDS designation prudently. A DDSO which chooses to use the OHCDS designation should send a request for approval to the Office of Waiver Management and Service Coordination for review. The request will then be forwarded to the Associate Commissioner of Upstate Support, Region 2 for approval.*

**A voluntary agency holding a Provider Agreement may be designated as an OHCDS if it meets these three criteria:**

1. It is a “system organized for the purpose of delivering health care,” approved by DOH to provide services from the HCBS waiver.
2. It furnishes at least one OMRDD HCBS waiver service itself.
3. Its employees who deliver the HCBS waiver service meet the state's minimum qualifications for provision of that service.

**An OHCDS may contract with another provider of service if that provider meets the following criteria:**

1. The contract agency is qualified to provide that service, i.e., satisfies all assurances given by OMRDD to HCFA for the HCBS waiver, except entering into a Medicaid provider agreement and,
2. Consumers are not restricted to services within the OHCDS but may choose each service from any approved provider and,
3. There is a properly executed contract between the OHCDS and the contract agency complying with 42 CFR 434.6 which:
  - a. Includes provisions for a sound and complete procurement contract (required by 45 CFR part 74, appendix G) and,
  - b. Identifies the population covered by the contract and,
  - c. Specifies any procedures for enrollment or re-enrollment of the covered population and,
  - d. Specifies the amount, duration, and scope of medical services to be provided or paid for and,
  - e. Provides that HCFA, DOH and OMRDD may evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract and,
  - f. Specifies procedures and criteria for terminating the contract, including a requirement that the contractor promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims and,
  - g. Provides that the contract agency maintains an appropriate record system for services to enrolled recipients and,
  - h. Provides that the contract agency safeguards information about recipients (required by 42 CFR 431, subpart F) and,
  - i. Specifies any activities to be performed by the contract agency that are related to third party liability (required by 42 CFR 433 subpart D).

# Other Regulatory Requirements Applicable to Persons Receiving HCBS Waiver Services<sup>1</sup>

## Parts 624, 633 and 636:

The “Official Compilation of Codes, Rules and Regulations of the State of New York,” Title 14 (14NYCRR), Part 635-10.1(c) states:

“...all authorized HCBS waiver providers shall comply with the requirements of Parts 624, 633 and 636 of this Title.”

## Part 624

All consumers are protected by Part 624. If a consumer resides in a community residence (which includes all IRAs) or a family care home, there are established agency policies and procedures in effect with regard to the reporting, investigation, standing committee review, and monitoring of incidents. If a consumer resides in his or her own home, procedures may be modified, but the process is applicable. The Part 624 Handbook contains suggestions for applying Part 624 in a non-certified setting (see Appendix).

## Part 633

OMRDD's philosophy in relation to the protection of people with developmental disabilities who are receiving services is set forth in this Part. Section 633.12 sets forth the administrative hearing process that would be followed if a consumer or advocate objects to and appeals an individualized plan of services (ISP), any part of it, or any proposed changes to it; any other care or treatment with which he or she disagrees; a plan to move from one community residence (including IRAs) or family care home to another, or any other setting; or a proposal by a service provider to discharge the consumer.

## Part 636

All records are confidential. Part 636 sets forth how access to these records is handled.

## Community Placement Procedures:

When a person who resides in a community residence (including IRAs) or a family care home is to move to a new address, there are certain procedures to be followed, including notification to interested parties and the provision for objecting to the change. For further information, refer to “Community Placement Procedures” (published January 1992/revised 1995).

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<sup>1</sup> Material may be obtained from Regulatory Affairs Unit, OMRDD, 44 Holland Avenue, Albany, NY 12229.

### DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

**I. Identifying Information**

(a). Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

(b) (To be completed by HCFA Regional Office) Chain Affiliate No. □□□□□ **LB1**

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

Yes  No **LB2**

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes  No **LB3**

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

Yes  No **LB4**

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
		<b>LB5</b>

(b) Type of Entity:  Sole Proprietorship  Partnership  Corporation **LB6**  
 Unincorporated Associations  Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

Yes  No **LB7**

Name	Address	Provider Number

IV. (a) Has there been a change in ownership or control within the last year?  
If yes, give date \_\_\_\_\_  Yes  No LB8

(b) Do you anticipate any change of ownership or control within the year?  
If yes, when? \_\_\_\_\_  Yes  No LB9

(c) Do you anticipate filing for bankruptcy within the year?  
If yes, when? \_\_\_\_\_  Yes  No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?  
If yes, give date of change in operations \_\_\_\_\_  Yes  No LB11

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?  
 Yes  No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name and address of Corporation, and EIN)  
 Yes  No LB13  
Name EIN #  
Address  
LB14

VII. (b) If the answer to Question VII.4a. Is No, was the facility ever affiliated with a chain?  Yes  No LB18  
Name EIN #  
Address  
LB19

VII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?  
 Yes  No LB15  
If yes, give year of change \_\_\_\_\_  
Current beds \_\_\_\_\_ LB16 Prior beds \_\_\_\_\_ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title
Signature	Date

Remarks

## INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT ((HCFA-1513))

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

### SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete Part II(a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

#### General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V	-42CFR 51a.144
Title XVIII	-42CFR 420.200-206
Title XIX	-42CFR 455.100-106
Title XX	-45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

#### DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

**Item 1 (a)** Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

**(b) For Regional Office Use Only.** If the yes box is checked for Item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

**Item II -** Self-explanatory.

**Item III -** List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishings services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

**Items IV - VII - Changes in Provider Status**

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

**Item IV - (a & b)** If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

**Item V** - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

**Item VI** - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

**Item VII** - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and director of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

**Item VIII** - If yes, list the actual number of beds in the facility now and the previous number.

**ADDITIONAL INSTRUCTIONS FROM THE  
NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES  
FOR COMPLETING HCFA-1513  
(For OMH and OMRDD)**

General Use of the word "same" in answer to any of the questions is not acceptable.

You will find one copy of the HCFA-1513 in your packet. Please make a second copy for your records.

Item III (a) & (b) Non-profit and Government-related organizations

Remarks Note your organization's status in answer to questions III (a) & (b) (i.e., non-profit, county operated, etc.). List your board of directors, their titles and addresses in remarks, or attache an existing list.

Item VII Chain Ownership

Remarks If you are a member of a chain, an individual form for each chain member need not be completed. A master form should be completed, and the names, addresses, and MMIS Provider I.D. Numbers of all the members must be attached.

PLEASE CLEARLY NOTE IN THE REMARKS SECTION OF THE FORM THAT THIS IS A MASTER COPY COMPLETED FOR THE ENTIRE CHAIN.

NOTE IN THE REMARKS SECTION OF THE FORM THAT YOU ARE EITHER AN OMH OR OMRDD CERTIFIED PROVIDER.

**AGREEMENT BETWEEN**

**THE NEW YORK STATE DEPARTMENT OF HEALTH  
AND  
A PROVIDER OF HOME AND COMMUNITY  
BASED WAIVER SERVICES**

This agreement is between the New York State Department of Health (DOH) and \_\_\_\_\_ (Provider), who is approved by the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) to provide New York State Home and Community-Based Services (HCBS Waiver Services). The services to be offered by the Provider are specified in the WAIVER PROVIDER APPROVAL form, which is attached to this agreement.

For the purpose of establishing eligibility for payment under Title XIX of the Federal Social Security Act, the Provider agrees to comply with applicable sections of Parts 624, 633, 635, and 636 of 14NYCRR; and with 42CFR 431.107; and with the standards of operation set forth in the OMRDD PROVIDER GUIDE TO THE INDIVIDUALIZED SERVICE ENVIRONMENT, and with all revisions and updates to this document.

The Provider also agrees to:

- I. Keep any records necessary to disclose the type and extent of services the Provider furnishes to recipients, and on request furnish to DOH, to DSS, to OMRDD, or to the Secretary of the U.S. Department of Health and Human Services, or to the State Medicaid Fraud Control unit, information regarding these services and payments claimed by the Provider under Title XIX.
- II. Comply with the disclosure requirements specified in 42 CFR Part 455, Subpart B.
- III. Abide by all applicable Federal and State laws; and all applicable regulations of DOH, DSS, OMRDD, and the Department of Health and Human Services.
- IV. Report all revenues and expenses associated with the provision of HCBS Waiver services using the forms and procedures established in the New York State Department of Mental Hygiene Consolidated Fiscal Reporting Manual.

- V. Submit claims for HCBS Waiver Services in accordance with instructions issued by DOH, DSS and OMRDD, specifically ensuring that services billed as HCBS Waiver services are not also billed to Medicaid under the existing State Plan services.
- VI. Submit claims for a period when the recipient is Medicaid eligible, approved for waiver participation, and not a resident of a Nursing Facility or Intermediate Care Facility for the Mentally Retarded.
- VII. Attend Fair Hearings and provide testimony regarding the recipient of HCBS Waiver Services when requested by DOH, DSS or OMRDD; and comply with such Fair Hearing decisions in accordance with 18NYCRR 358-6.4.

This agreement shall be effective upon approval by DOH and shall remain in effect no later than August 31, 1999.

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**(DDSO Letterhead)**

**OMRDD HOME AND COMMUNITY-BASED WAIVER**

**WAIVER PROVIDER APPROVAL**

Provider: \_\_\_\_\_

Federal ID # \_\_\_\_\_

The above named provider is qualified and approved to provide the following specific Home and Community-Based Waiver services in accordance with the regulations and guidelines issued by OMRDD pursuant to Article 16 of the Mental Hygiene Law. This approval constitutes certification of specified services.

<u>Service</u>	<u>Effective Date</u>
<input type="checkbox"/> Residential Habilitation	_____
<input type="checkbox"/> Day Habilitation	_____
<input type="checkbox"/> Prevocational Services	_____
<input type="checkbox"/> Supported Employment	_____
<input type="checkbox"/> Respite Services	_____
<input type="checkbox"/> Environmental Modifications	_____
<input type="checkbox"/> Adaptive Technologies	_____
<input type="checkbox"/> Family Education and Training	_____
<input type="checkbox"/> Plan of Care Support Services	_____
<input type="checkbox"/> Consolidated Supports and Services (CSS)/ Fiscal Employer Agent (FEA)	_____
<input type="checkbox"/> Transitional Supports	_____

\_\_\_\_\_  
DDSO Director

\_\_\_\_\_  
Date



(DDSO/NYCRO Letterhead)

OMRDD HOME AND COMMUNITY-BASED WAIVER

WAIVER PROVIDER APPROVAL

Provider: \_\_\_\_\_

Federal ID # \_\_\_\_\_

The above named provider is qualified and approved to provide the following specific Home and Community-Based Waiver services in accordance with the regulations and guidelines issued by OMRDD pursuant to Article 16 of the Mental Hygiene Law. This approval constitutes certification of specified services.

<u>Service</u>	<u>Effective Date</u>
<input type="checkbox"/> Residential Habilitation	_____
<input type="checkbox"/> Day Habilitation	_____
<input type="checkbox"/> Prevocational Services	_____
<input type="checkbox"/> Supported Employment	_____
<input type="checkbox"/> Respite Services	_____
<input type="checkbox"/> Environmental Modifications	_____
<input type="checkbox"/> Adaptive Technologies	_____
<input type="checkbox"/> Family Education and Training	_____
<input type="checkbox"/> Plan of Care Support Services	_____
<input type="checkbox"/> Consolidated Supports and Services (CSS)/ Fiscal Employer Agent (FEA)	_____
<input type="checkbox"/> Transitional Supports	_____

\_\_\_\_\_  
DDSO Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Associate Commissioner  
NYC Regional Office

\_\_\_\_\_  
Date



# Chapter 13 - FUNDING

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## **Funding and the ISE**

A fundamental principle of the Individualized Service Environment is that it should enhance a person's integration into the community. By extension, this principle affects how financial resources are organized and accessed - including Medicaid funding for home and community based services. OMRDD has designed the ISE to maximize the use of non-OMRDD funding. This is accomplished through a person centered service planning process, which accents the use of natural supports, generic supports or services available to all people in a community, and the use of specialized services available from or through other federal, state, or local sources. These sources are to be considered along with OMRDD funding opportunities which include the HCBS waiver.

In its guidelines and training, OMRDD refers to this variety of resources as the ISE Pyramid (see Chapter 4, "Natural Supports"). It makes clear that the primary benefit of accessing a variety of sources for different supports and services is to maximize integration within the community while minimizing a person's dependence on specialized services and specialized funding. A secondary (and quite significant) benefit is that OMRDD's financial contribution to an individual is contained to the extent that other sources can provide the supports or services requested. This allows OMRDD to meet the needs of more people who have developmental disabilities than would otherwise be possible.

The ISE Pyramid identifies a number of funding sources which OMRDD controls. Primary among them is the Home and Community Based Services waiver. This Medicaid based funding source contributes to the service plans of almost 30,000 people. While a great many more receive ISE based supports or services through the Family Support Service and Individual Support Service programs or similar services, the gross dollar value of HCBS funding far outstrips those funding sources.

## **The Community Services Plan**

OMRDD initiated a new decision making process in 1993 which covers service funding in support of the Individualized Service Environment. This new process is called the Community Services Plan (CSP). Through the CSP, OMRDD funding for the ISE, including all HCBS services, is managed by the Developmental Disabilities District Offices (DDSO) or the New York City Regional Office (NYCRO).

### **Budget Allocations and Priority Populations**

Each DDSO or the NYCRO receives a CSP allocation for each fiscal year. These offices have the discretion to manage this on a regional basis or to further suballocate their CSP monies to each county in their catchment area. The DDSOs are expected to spend this allocation for supports and services to individuals who fall into one of three categories of priorities: priority populations identified in the legislative appropriation, agency-wide priority populations, and locally identified priority populations.

In combination, priorities set through these three mechanisms provide the framework for decision making at the DDSO level. All requests for supports or services, including those related to the enrollment of people in the HCBS waiver, are reviewed within the context of these priorities.

DDSOs have discretion regarding how requests for supports and services are processed. Current practice typically includes a formal cycle for solicitation of requests for supports and services. This formal cycle of solicitation can be annual or more frequent. It includes notification of the availability of funding, criteria for consideration (including priorities), and an explanation of the process and time frames for decision making. DDSOs are expected to provide timely decisions to all requests for supports and services and to provide regular information on the status of any request.

All DDSOs will accept requests for supports and services throughout the year in addition to these formal cycles. Every DDSO also has a procedure for responding immediately to requests for supports or services which involve individuals or families in crisis who require immediate intervention.

### **Local Review of Decisions**

Requests for supports and services, regardless of their origin, are typically reviewed by local committees convened by the DDSO for that purpose. These committees must include consumers and families, provider representatives, and DDSO management, but also may include representatives of local government, the community, or other local stakeholders. These committees review the requests using established time frames, criteria, and protocol for communicating with individuals, families, or agencies submitting requests.

The requests for supports and services are reviewed against three basic factors. The first is how the individuals to be served fit within the priorities established for the funding cycle. The proposed supports and services are then evaluated against the identified valued outcomes or needs of the individuals who will receive them. Finally, the cost-effectiveness of the anticipated price for involved supports and services is assessed. Included in the assessment of cost-effectiveness is the potential for using resources other than or in addition to CSP dollars (i.e. natural supports, other state funding, Medicaid, etc.).

The local review committee advises the DDSO Director that the request does or does not meet the established priorities and whether the proposed price is cost effective. The director, after review and discussion, then makes the decision and notifies the party who made the request. It is at this time that people who are, or appear to be, eligible for the Home and Community Based Services Waiver are informed that they should submit an application for enrollment or, if their request for services came to the DDSO in the form of an HCBS application, that their application is authorized. (See "Individual Enrollment," Chapter 2.)

## Who Pays For HCBS Services?

The cost of HCBS waiver services is jointly borne by New York State and the federal Medicaid program. The federal Medicaid program pays for 50% of the approved cost.

OMRDD manages the state dollars used to pay for these services and, in collaboration with the New York State Department of Health (DOH), the federal Medicaid dollars. At the current time, counties are not required to provide any funding for waiver services. Their share is being funded by OMRDD. Private, voluntary providers may deliver HCBS services, but OMRDD pays for them.

### Making Payments For HCBS Services

Once services are delivered, the agency must “bill” the HCBS funding agency, using appropriate voucher forms provided by OMRDD. The voucher identifies the service month and service type, individuals served, the number of units of service provided to each individual, the price ID and price authorized by the DDSO for that individual, and the amount due. The vouchers are divided into two categories: those enrolled in Medicaid, and those receiving waiver services but not enrolled in Medicaid (see Special Note regarding “non-HCBS” individuals).

Up-to-date billing information and voucher forms are available through the local DDSO, or from the Bureau of Community Funding at 30 Russell Road, Albany, New York 12206.

If a voluntary, not-for-profit agency delivered the service, that agency submits a bill (voucher) to OMRDD (Bureau of Community Funding). That bill (voucher) identifies who received the service(s), when the services were received, number of units of services delivered, and agreed upon billing price per unit. Once the billing information is verified, OMRDD processes the bill (voucher) for payment and sends it to the Office of the State Comptroller, which authorizes release of the check and mails it to the agency.

If the service was delivered by OMRDD staff, the necessary information is recorded in TABS (Tracking and Billing System). OMRDD’s Central Office, using the service activity data recorded in TABS, routinely bills the federal government, through DOH, for payment of the Medicaid portion that will be reimbursed.

*In certain circumstances, authorized agencies may receive advance payments when the time required for formal Medicaid billing and payment would create fiscal hardship.* These advance payments are not Medicaid payments but OMRDD payments. If an advance payment is received, the agency must agree to allow OMRDD to recoup the advance payment as the agency bills for HCBS services which are delivered.

## Setting Payment Levels for HCBS Services

HCBS payment levels are set through the Community Services Plan process, using three mechanisms: statewide prospective fee, budget based reimbursement prices, and contracts. These payment mechanisms are the same for services delivered by voluntary agencies and those delivered by OMRDD staff.

**A statewide prospective fee** was created for Waiver Service Coordination (case management). The fee is a monthly fee. The level of payment was determined by using average salary levels for staff with necessary qualifications, appropriate supervision, support, administration and other than personnel costs; setting an average caseload of 20 people per service coordinator; and dividing the typical monthly cost by caseload. This fee assumes a reasonable salary for service coordinators, appropriate support and supervision, and an average of between 5 and 6 hours each month spent working with or on behalf of each individual.

**Budget Based Reimbursement Prices** are used to pay for residential habilitation, day habilitation, respite, supported employment, and prevocational services. The term "price" is used to connote that these payment levels are set through a mechanism which differs from the "rate-setting" mechanism for ICFs/MR. The price is the amount of payment that OMRDD agrees to pay an agency for a support or service chosen by the consumer and designed for the consumer. Any price is driven by the Individualized Service Plans developed for those people who will receive the service. (See Chapter 7, "Individualized Service Plan" for an explanation of the applicable information that should be included in this planning document.)

The most up-to-date information related to setting prices and adjusting prices is available through the local DDSO.

**Two types of prices exist: Fixed Prices or Developed Prices.** Fixed prices are prices within the community which are the same regardless of who is receiving the service. Examples of such prices would be memberships to community organizations such as the YWCA or the Jewish Community Center. The fixed price exists prior to a specific request for service. Fixed prices may also include fixed hourly or per diem prices by a non-OMRDD generic local agency and are not typically applicable to voluntary not-for-profit agencies that deliver MRDD services under the HCBS waiver (see memo from OMRDD Deputy Commissioner for Administration and Revenue Support to DDSO Directors and CSEP Coordinators, dated February 2 , 1996). Fixed prices such as these vary only by the staff who are providing the service: for example, a nurse versus an occupational therapist.

Developed prices are those prices which are based on a Price Proposal Summary for an individual or group of individuals. In this instance, the provider compiles a series of costs specifically related to specific people. Budgets for developed prices may include fixed prices such as memberships or the cost of taxi or bus fare. Developed prices may be established by the provider and accepted by the DDSO or New York City Regional Office - or the DDSO or NYCRO may use the budget developed by the provider to establish a price which is acceptable. Developed prices must be calculated based on the budgeted costs that appear on the CSP Price Proposal Summary. All

developed prices should undergo the budget review process which is explained in OMRDD's "CSEP Pricing Guide." OMRDD also has made Price Setting Software available for use by the DDSO or NYCRO in their budget review process. This software is required to be submitted to the OMRDD Bureau of Rate Setting in order to be able to initiate the billing process.

The DDSO or NYCRO has authority to approve most prices locally, within guidelines set by New York State's Division of Budget. Prices which exceed these guidelines are considered "outliers" and require approval by the Division of Budget before services can be delivered.

Prices set through this process may be adjusted. Adjustments that can be made at the DDSO or NYCRO include those based on: capacity changes in the group used for the original price, changes in ISPs for involved consumers, relocations or conversions made at the local level, extended vacancies in the group the original price was set for, shortfall of SSI benefits, or adjustments to cost categories (i.e. staffing, fringe benefits, OTPS, administration, etc.). Central Office is responsible for price adjustments related to: annual property cost revisions including MCFFA bonding, annual trend adjustments, corrections due to calculation error, and recoupments. Details related to price adjustments can be obtained from OMRDD's Bureau of Rate Setting.

**Contract Based Payments** are used for Adaptive Devices and Environmental Modifications. Setting contract amounts and payment activities follow typical procurement and approval processes for State contract purchases. For contracts up to \$5,000 the consumer, advocate or involved provider, using device specifications or scope of work, respectively, solicit written quotations which include all terms and conditions for the sale of the adaptive device or the work to be accomplished in the environmental modification. For contracts above \$5,000 a minimum of 3 comparable written bids must be solicited (if sufficient vendors are available).

Once the appropriate bids or quotations are collected, the consumer, advocate or involved family care provider submits them to the DDSO or NYCRO, identifying the low bidder. If a voluntary agency authorized to provide either Adaptive Devices or Environmental Modifications under the HCBS waiver is involved, that agency may just inform the DDSO or NYCRO of the estimates or bids and the selected vendor.

Contracts under \$10,000 may be fully executed upon signing by the DDSO director and submitted to OMRDD's Budget and Fiscal Services for processing. Contracts for \$10,000 or more must follow standard contract processing procedures, which result in full execution upon approval by the New York Office of State Comptroller and the State Attorney General.

For more detailed information on this process, please see Chapters 10 and 11 of this manual.

## Special Notes:

### Accommodation of Vacancies and Therapeutic Leave Days

In November of 1995 OMRDD clarified that the Health Care Financing Administration would not allow HCBS billings for days when services were not delivered. This resulted in prohibition of billing for “vacant” or “therapeutic leave” days under the HCBS waiver. In a memo to DDSO directors dated November 1, 1995, OMRDD’s Deputy for Administration and Revenue Support indicated that such issues were to be considered “vacancy adjustments” and outlined how they were to be handled in the development of prices related to HCBS services. In conclusion, that memo also stated that “anticipated vacancies” must be specified in the individual service plans in order to be counted in the per diem calculation. That memo further clarified the impact of this new policy on services being provided in Community Residences where Part 671 Residential Habilitation was being delivered.

### Provider Agreement Requirement

In order to be eligible for direct payment for waiver services an agency or provider must have a valid Provider Agreement to deliver Medicaid funded HCBS services. If an agency or provider seeks to provide selected components of an HCBS service by subcontracting with another agency, provider or vendor, it must be authorized as an Organized Health Care Delivery System. See the Chapter 12, “Becoming a Provider” for details.

### Medicaid -- Payor of Last Resort

Federal regulations require that Medicaid be the payor of last resort for any eligible services. This means that, especially for Adaptive Devices and Environmental Modifications, a consumer, family or provider is obligated to first bill alternative coverages, such as private insurance, that may be available to the HCBS-enrolled individual.

### Payment for HCBS Waiver Services

Currently all HCBS waiver service payments to voluntary agencies are processed by OMRDD’s Bureau of Community Funding or DDSO/NYCRO except payments for Part 671 Residential Habilitation which is provided only in certified Community Residences (which is paid through the Medicaid Management Information System - MMIS). At some point in the future it is expected that most HCBS waiver service bills will be submitted to the MMIS for processing and payments. At such time appropriate instructions and training will be made available and this section will be revised accordingly.

### Block Funding for HCBS Services

In October of 1994 OMRDD authorized DDSOs or the NYCRO to consider using block funding for agencies providing HCBS services that have fixed or developed prices. Block grants, at that time, were defined as “an agreement between a DDSO and a voluntary agency to have the agency provide CSEP-funded services to a set number of individuals who meet agreed-upon profiles (Individual Services Planning Model, specific disabilities, specific target groups, etc.) for an

agreed-upon aggregate CSEP dollar amount. Consumers with similar problems may be interchanged without amending the agreement....” Guidelines for prices set through this block grant process were stated in an October 14, 1994 memo from the Commissioner of OMRDD which was sent to all DDSO directors and titled “Block Grants.” They required the following assurances:

- A block grant does not undermine a fair and equitable allocation of resources.
- A block grant must be individually based, including identifying individuals to be served...or at least a concrete group of individuals.
- All block grants must be responsive to local priorities set through the local collaborative priority setting processes established for CSEP.
- Block grants should be reviewed by CSEP consumer advisory councils, to the extent possible.
- Should consumers not subscribe to this service option, the DDSO will terminate its usage.
- This option must not infringe on a consumer’s right to choice of provider.

### **Payment for Services to Non-HCBS Individuals**

OMRDD has developed mechanisms for reimbursing the costs of waiver services for “non-HCBS” individuals as well as for consumers enrolled in the waiver. The price setting and payment mechanisms are the same for each category. However, the source of funding will differ. In transactions invisible to the consumer, OMRDD uses 100% state dollars to pay the costs of waiver services to consumers who are not enrolled in the waiver -- payment that is *not* offset by federal Medicaid dollars. The purpose of integrating these payment mechanisms is to minimize the difference in how Medicaid and non-Medicaid consumers have their ISE-related services paid.

### **Cap on Environmental Modifications**

OMRDD has established fiscal year State Share funding ceilings per individual for environmental modifications. For people enrolled in the HCBS waiver, the State Share ceiling is \$7,000. When combined with its federal Medicaid match under the waiver, a total of \$14,000 may be spent in any given fiscal year on environmental modifications for an individual. 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. The \$7,000 OMRDD State Share ceiling affects only environmental modifications and **does not** apply to Adaptive Devices or any other HCBS service. (See Chapters 10 and 11 for information related to E-Mods and Adaptive Devices.)

## **Environmental Modifications and Adaptive Devices as Capital Expenditures**

The only HCBS waiver services that are funded as capital expenditures are Environmental Modifications and Adaptive Devices. Capital appropriations are managed differently within OMRDD than appropriations for payments for operating expenses. Therefore, a DDSO or NYCRO does not have the same latitude when deciding which requests can be funded. Their access to capital appropriations may be more restricted, and they cannot substitute operational appropriations or allocations for capital expenditures.

# Chapter 14 - QUALITY

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## **Background**

OMRDD, by promoting the Individualized Service Environment (ISE), has moved the focus of service planning and delivery to providing quality services and supports which are responsive to an individual's personal goals, valued outcomes, and capabilities. Emphasizing consumer empowerment, informed choice, and community integration, the ISE has introduced significant new elements that affect the assessment of quality. Supporting consumer choice leads to situations that require greater professional discretion. For example, questions of acceptable risk are now encountered which are so person-specific that historically accepted standards have to be re-evaluated. Factors are surfacing in everyday life now, that were not anticipated during the formulation of many regulations which currently govern our system. The new ISE focus reshapes what is possible, what is desirable, and what is expected of the service system.

Within this sea of change, one constant is the provider's commitment to the health and safety of the individuals who need support. Constant also is the commitment of the provider community, in both its public and private sectors, to delivering quality services which support consumer choice, demonstrate the highest levels of professional integrity and competence, and comply with applicable laws and regulations. The commitment to quality remains unchanged, but the mechanisms for measuring quality are rapidly evolving in response to new possibilities and expectations.

## **Governing Principles**

OMRDD has recently introduced a new set of governing principles as a statewide yardstick of quality to strengthen the service delivery system's commitment to quality services and supports. The five governing principles are intended to ensure that people with developmental disabilities receive supports and services, within available resources and based upon the individual's choices and needs. The supports and services should assist people to live successfully in their chosen environment.

These principles are:

1. A person with a developmental disability should relate to his/her family, friends, and communities when and how they choose, consistent with the rights and wishes of others.
2. A person with a developmental disability shall be as independent as possible and determine the direction of his or her life.
3. A person with a developmental disability shall have the opportunity to make life choices that do not compromise health and safety, and such choices shall be respected and valued.
4. A person with a developmental disability should 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.

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

The five principles, together with a parallel effort to streamline the OMRDD regulations to make them consistent with the principles and the Mental Hygiene Law, will help to positively guide the behavior of organizations and their employees on behalf of people with developmental disabilities. OMRDD will create operating principles for each type of program. The operating principles will be included in OMRDD's regulations, and new regulatory standards will be based on them.

## **Quality Assurance and the ISE**

The OMRDD Division of Quality Assurance has the organizational responsibility for external oversight of supports and services delivered through the Individualized Service Environment, including services funded through the HCBS waiver as well as other sources. This responsibility, originally held by the DDSO, was transitioned to DQA during the fall and winter of 1995/6.

A provider's efforts to plan and deliver quality services were once measured predominately, if not exclusively, on the basis of their conformity with applicable federal and state regulations. Currently, regulations are considered the minimum expectations for the provision of quality supports and services, and compliance is not the only indicator of quality services. Reviews based solely on regulations as an indicator of quality are to be replaced by an assessment of a provider's achievement and promotion of consumer valued outcomes as an alternative indicator of quality. These reviews will be conducted by OMRDD's Quality Assurance staff.

Pending changes emanating from OMRDD's regulatory reform process, review of the provision of supports and services will be based on four factors:

- A provider's efforts to promote and achieve a person's valued outcomes.
- A provider's adherence to the safeguards articulated in 14NYCRR Parts 624, 633, and 635.
- A provider's adherence to the governing principles for quality.
- A provider's compliance with requirements for HCBS services articulated in the most current Provider Guide for the HCBS waiver.

Expectations of quality, with regard to provider performance, have broadened from compliance with regulation to services that present a "level of excellence." Quality continues to be a primary responsibility of the provider of service. Quality services cannot be achieved by simply satisfying sources external to the provider organization. A provider should not wait until an external survey occurs to identify areas for improvement. Self-evaluation and self-correction by the provider agency are indicators of a commitment to quality.

Providers of quality services should strive to offer individual opportunities for consumers that promote independence, inclusion, and productivity. Yet, consumers and providers must be aware that the service delivery system is not able to satisfy every choice. The reality of limited resources influences everyone's choices. Agencies and consumers may need to reconcile the ideal with the practical in their efforts to provide the best individually tailored services possible.

Consumer education and knowledge are essential prerequisites to achieving meaningful levels of customer satisfaction - another crucial component of quality services. Consumers participating in education and training will broaden their understanding of service quality. As a result, the validity and value of satisfaction surveys will improve as consumers become more insightful.

A provider of quality services should systematically solicit consumer opinion and attempt to ensure that there is a high level of consumer satisfaction with service provision. However, a provider should realize that high satisfaction levels may sometimes compete with the delivery of desirable services and safeguards.

For example, a person with a developmental disability who prefers and does spend inordinate amounts of time watching TV in lieu of participating in new community activities may express satisfaction to the provider. Several questions could be asked: "Has this provider fully served the consumer in a quality manner?" "Should the provider do more to help the consumer to improve the quality of his/her life?" "Has the person's TV watching become so pervasive that the provider now has an obligation to introduce the consumer to new experiences?"

Disagreements may arise when we attempt to balance consumer choice with provider responsibility to ensure a person's health and safety. However, providers should try to maximize consumer satisfaction. This most often is accomplished through a mechanism for conflict resolution, another key step toward providing quality services. These mechanisms for quality are only initial steps in a provider organization's pursuit of excellence.



# Appendix A

## ACRONYMS

ACD	Alternate Care Determination
CAB	Consumer Advisory Board (for Willowbrook Class Members)
CBVH	Commission for the Blind and Visually Handicapped
CMCM	Comprehensive Medicaid Case Management
CQC	Commission on Quality of Care for the Mentally Disabled
CR	Community Residence
CSP	Community Services Plan
DDPC	Developmental Disabilities Planning Council
DDSO	Developmental Disabilities Services Office
DME	Durable Medical Equipment
DOH	(New York State) Department of Health
DQA	Division of Quality Assurance
DSS	
	· LDSS      Local Department of Social Services
	· SDSS      State Department of Social Services
EASY	Electronic Application System
EIP	Early Intervention Program
E-Mods	Environmental Modifications
Fannie Mae	Federal National Mortgage Association
FC	Family Care
FSS	Family Support Services
HCBS	Home and Community Based Services Waiver

HCFA	Health Care Financing Administration
HUD	Housing and Urban Development
IPP	Individualized Program Plan
IRA	Individualized Residential Alternative
ISE	Individualized Service Environment
ISP	Individualized Service Plan
ISS	Individual Support Services
LCED	Level of Care Eligibility Determination
MA	Medicaid
MCFFA	Medical Care Facilities Finance Agency
MHLS	Mental Hygiene Legal Service
MMIS	Medicaid Management Information System
NOD	Notice of Decision
OHCDS	Organized Health Care Delivery System
OMRDD	Office of Mental Retardation and Developmental Disabilities
OT	Occupational Therapist (or Therapy)
PADD	Protection and Advocacy for the Developmentally Disabled
PISP	Preliminary Individualized Service Plan
PT	Physical Therapist (or Therapy)
QMRP	Qualified Mental Retardation Professional
RSFO	Revenue Support Field Office
SRU	Small Residential Unit (of an ICF/MR)
TABS	Tracking and Billing System
TRAID	Technology-Related Assistance for Individuals with Disabilities
TUBS	Temporary Use Beds

UR	Utilization Review
URAC-2	Utilization Review Admission Criteria -- also known as ICF Level of Care Eligibility Determination Form
VESID	Vocational and Educational Services for Individuals with Disabilities
WMS	Welfare Management System



## Appendix B

### EXCERPTS FROM PART 624 HANDBOOK

#### Part 624.1(d)

Pursuant to Part 635-10.1(c), Home and Community Based Waiver Services (HCBS) providers shall comply with the requirements of this Part.

#### Commentary:

- Part 635-10.1(c) states:

“In addition, all authorized HCBS waiver providers shall comply with the requirements of Parts 624, 633 and 636 of this Title.”

Therefore, situations which meet the definition of reportable incident, serious reportable incident or alleged abuse which occur to people receiving waiver services, even in non-certified settings, and which are known to a provider of waiver services, are to be reported and follow-up activities must occur.

- A “non-certified setting” is a place where services are delivered, but that place does not carry OMRDD certification. A person’s own home would be a non-certified setting. Another example of services delivered in a non-certified setting would be day habilitation services provided in the community. Home and Community Based Waiver services are an example of a certified service that can be provided in a non-certified setting.
- If waiver services are being provided to a person who resides in or attends a certified facility, strict adherence to Part 624 is required, and “facility” procedures are to be followed.
- If, while receiving waiver services at a non-certified location, a situation (which meets the definition of a reportable incident, serious reportable incident, or alleged abuse) occurs to a person who resides in an OMRDD certified facility, the residential facility assumes the responsibility for handling the situation. (Also see §624.5(d)(1), page 70.)
- If a reportable incident, serious reportable incident or alleged abuse occurs in which staff of any provider of waiver services are directly involved, the situation is to be handled as though the event occurred in a facility, regardless of where the event occurred.

- When waiver services are provided to persons who do not live in a certified facility and the services are delivered in the person's own home or another non-certified location, the service provider should utilize the agency's current process with regard to record keeping, investigations, review by the standing committee, and monitoring.
- When waiver services are provided to persons who do not live in a certified facility and the services are delivered in the person's own home or another non-certified location, it is suggested that:
  - At the time of intake, the consumer, family, or other involved parties should be advised of the requirements of Part 624 with regard to staff recording those situations of which they are aware that meet the definition of a reportable incident, serious reportable incident, or alleged abuse; of the requirement for the situation to be assessed and, possibly, investigated; of the requirement that any child abuse be reported to the Child Abuse Register; and of the requirement that any crime committed against a consumer be reported to the local law enforcement authority (Mental Hygiene Law §16.13).
  - The consumer, family, or other involved parties should be provided with information as to the policies and procedures that will be followed when a situation that meets the definition of a reportable incident, serious reportable incident or abuse is known to the waiver service provider.
  - All situations that meet the definition of a reportable incident, serious reportable incident or abuse that are known to a provider of waiver services should be recorded in a uniform manner as established by the agency receiving the reports, and acted upon as the situation dictates. For instance:
    - Assess the situation (e.g., is there an indication of a pattern of inappropriate care at home, inability of a person living alone to cope with demands of daily living, possible abuse, unsafe physical environment?)
    - Report possible crimes committed against a consumer to appropriate law enforcement authorities.
    - Report alleged child abuse to the New York Child Abuse and Maltreatment Reporting Center by telephone at 1-800-342-3720.
    - Report alleged abuse of an adult to adult protective services.
    - Advise the advocate and service coordinator (case manager) of the situation.
    - Determine, with input from the case manager, if support services or other assistance (e.g., counseling, sexuality counseling or education, psychiatric or psychological services, education on positive care giving) should be provided to the consumer, his or her family, or others, whether by the agency or arranged for through the case manager.

- Advise other providers of services of the situation.
- Immediately notify the DDSO of any situation reported to law enforcement authorities or Department of Social Services child or adult protective services.
- Notify the DDSO of any potentially sensitive situations.

**Note:** If the provider of services does not have the administrative structure to facilitate the necessary monitoring of the situation and review by a standing committee, the situation should be brought to the attention of the DDSO for technical assistance and guidance.

- When those providing waiver services in non-certified settings report situations that meet the definition of a reportable incident, serious reportable incident, or alleged abuse to a supervisor, the ground-work is laid for monitoring the situation so as to protect the consumer, to the extent possible, from other events that could be avoided had there been appropriate intervention or assistance if a pattern had evidenced itself. It would also be prudent to note other situations that are not as egregious for the same reason.
- See page 198 of the Part 624 Handbook for further information on the management of untoward events when other non-certified services (non-waiver) are being provided.



## Appendix C

### SUMMARY OF HCBS FORMS

#### Chapter 2 - Individual Enrollment

Form Name (as referenced in Provider Guide)	HCBS Form Name/Number	Number of Pages
Application for Participation	HCBS Form 02.01.97	1 Page
ICF/MR - Level of Care Eligibility Determination Form (Form Instructions)	HCBS Form 02.02.97	1 Page 10 Pages
Documentation of Choices	HCBS Form 02.03.97	1 Page
Preliminary Individualized Service Plan	HCBS Form 02.04.97	2 Pages
Notice(s) of Decision - HCBS Waiver Authorization Denial of Application HCBS Waiver Termination	HCBS Form 02.05.97 HCBS Form 02.06.97 HCBS Form 02.07.97	4 Pages 3 Pages 3 Pages
Change in Status (Change of District)	HCBS Form 02.08.97	1 Page
Change in Status (Change Within District)	HCBS Form 02.09.97	1 Page

#### Chapter 7 - Individualized Service Plan

Form Name (as referenced in Provider Guide)	HCBS Form Name/Number	Number of Pages
Individualized Service Plan	OMRDD ISP Form 4/05	8 Pages

#### Chapter 9 - Respite Services

Form Name (as referenced in Provider Guide)	HCBS Form Name/Number	Number of Pages
Guest Respite Home Survey - For One and Two Family Dwellings	OMR-Form-236R-Adm. Rev. 12/00	4 Pages

#### Chapter 10 - Environmental Modifications

Form Name (as referenced in Provider Guide)	HCBS Form Name/Number	Number of Pages
HCBS Environmental Modifications Contract	EM-HCBS 11/92	1 Page Cover Sheet 18 Pages Contract and Appendix
SOIRA Environmental Modifications Reporting Form	EM-1 1/93	1 Page (Instructions on back)
Family Care/At Home Environmental Modifications Reporting Form	EM-1A 1/93	1 Page (Instructions on back)

Standard Voucher	AC 92 Rev. 5/88	1 Page (Instructions on back) (Available at DDSO)
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Chapter 11 - Adaptive Devices

Form Name (as referenced in Provider Guide)	HCBS Form Name/Number	Number of Pages
HCBS Adaptive Technologies Contract	AT-HCBS 1/93	1 Page Cover Sheet 18 Pages Contract and Appendix
SOIRA Technology Reporting Form	APT-1 1/93	1 Page (Instructions on back)
Family Care/At Home Adaptive Technologies Reporting Form	APT-1A 1/93	1 Page (Instructions on back)
Standard Voucher	AC 92 Rev. 5/88	1 Page (Instructions on back) (Available at DDSO)

Chapter 12 - Becoming a Provider of Service

Form Name (as referenced in Provider Guide)	HCBS Form Name/Number	Number of Pages
Disclosure of Ownership and Control Interest Statement (HCFA 1513)	HCBS Form 12.01.97	2 Pages 2 Pages Instructions
Provider Agreement	HCBS Form 12.02.97	2 Pages
Waiver Provider Approval	HCBS Form 12.03.97 (7/05)	1 Page

## Appendix D

*Revised 3/29/07*

### The following Administrative Memorandums:

- Administrative Memorandum - #2002-01: IRA Residential Habilitation Service Documentation Requirements
- Administrative Memorandum - #2002-02: Supported Employment Service Delivery and Documentation Requirements
  
- Administrative Memorandum - #2003-01: Registered Nursing Supervision of Unlicensed Direct Care Staff in Residential Facilities Certified by the Office of Mental Retardation and Developmental Disabilities
- Administrative Memorandum - #2003-02: Plan of Care Support Services
- Administrative Memorandum - #2003-03: Habilitation Plan Requirements
  
- Administrative Memorandum - #2004-01: At-Home Residential Habilitation Service Documentation Requirements
- Advisory on Medicaid Service Coordination (MSC) and Plan of Care Support Services (PCSS) Service Coordinator ISP Responsibilities (dated February 17, 2004)
  
- Administrative Memorandum - #2005-01: Standards for Article 16 Clinics
- Administrative Memorandum - #2005-02: HCBS Respite/Non-Waiver Enrolled (NEW) Respite Service Documentation Requirements
  
- \* Advisory on Changes to the Individualized Service Plan (ISP) Format (dated January 14, 2005)
- \* See ISP Form and Instruction in Chapter 7
  
- Advisory Memorandum- Assistive Technology (Environmental Modifications & Adaptive Devices) (dated May 20, 2005)
  
- Administrative Memorandum - #2006-01: Group Day Habilitation Service Documentation Requirements
- Administrative Memorandum - #2006-02: Individual Day Habilitation Service Documentation Requirements
- Administrative Memorandum - #2006-03: Service Documentation Requirements for Prevocational Administration and Revenue Support
- Administrative Memorandum - #2006-04: Family Care Residential Habilitation Service Documentation Requirements

Please refer also to the OMRDD Web Site ([www.omr.state.ny.us](http://www.omr.state.ny.us)) for the MSC Technical Bulletins, which contain further updated information that can be printed.

- Click on "General Information and Publications" on left side of screen
- Scroll down and click on Publications in "Forms, Manuals and Publications"
- Click on OMRDD Administrative Memoranda





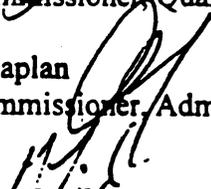
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**Administrative Memorandum - #2002-01**

**To:** Executive Directors of Agencies providing Individualized Residential Alternative (IRA) Residential Habilitation Waiver Services  
Executive Directors of Agencies providing Medicaid Service Coordination

**From:** Jan Abelseth   
Deputy Commissioner, Quality Assurance

Alden B. Kaplan   
Deputy Commissioner, Administration and Revenue Support

Gary Lind   
Director, Policy, Planning and Individualized Initiatives

**Subject:** IRA Residential Habilitation Service Documentation Requirements

**Date:** September 3, 2002

**Suggested Distribution:**

Program/Service Staff  
Quality/Compliance Staff  
Billing Department Staff  
MSC Service Coordinators

**Purpose:** This is to advise you that documentation for IRA Residential Habilitation services delivered on or after July 1, 2002 must meet the criteria set forth below. These criteria apply to IRA Residential Habilitation services rendered to Home and Community Based Service (HCBS) waiver enrolled individuals, as well as to non-enrolled individuals. The service documentation requirements set forth in this Administrative Memorandum supersede fiscal audit service documentation requirements addressed in The Key to Individualized Services, OMRDD's HCBS Waiver Policy Manual. Quality service standards remain the same.

**Background:** Effective July 1, 2002 the unit of service for IRA Residential Habilitation was changed from a day to a month. Title 14 of the Official Compilation of Codes, Rules and



Regulations of the State of New York Part 635-10.5(b) states new reimbursement and payment provisions for residential habilitation services provided in IRAs that took effect July 1, 2002. On July 1, 2002 IRA sites were designated supervised or supportive. See Attachment A for the definitions for supervised and supportive IRAs.

With the change in the unit of service, providers are required to meet new billing standards and comply with new service documentation requirements to substantiate monthly IRA Residential Habilitation billings. The federal Centers for Medicare and Medicaid Services' (CMS) HCBS Waiver Review Protocol lists elements that must be included in the documentation of HCBS Medicaid payment claims. Based on the federal listing, this OMRDD administrative memorandum provides clarifying information on the required components of acceptable service documentation for IRA Residential Habilitation Services.

Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York, Section 504.3 states that by enrolling in the Medicaid Program, "the provider agrees ... to prepare and to 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.

### **IRA Residential Habilitation Billing Standards**

#### **Supervised IRA Billing Standards**

The unit of service for supervised IRA residential habilitation services is a calendar month. The provider determines whether minimum services have been provided to bill a full month or a half-month for an individual resident based on the following:

To bill a **full month** for any resident:

1. The resident must be enrolled in the provider's supervised IRA program for a minimum of 22 days in a calendar month. "Enrollment" is defined as the time period commencing with the day of admission, up to and including the day of discharge.
2. The IRA staff must deliver and document a minimum of 22 separate days of face to face residential habilitation services, known as "countable service days", in accordance with the resident's ISP and Residential Habilitation Plan. A countable service day requires documentation of at least one residential habilitation staff service or action.

3. Days in a hospital, nursing home, ICF or other certified, licensed or government funded residential setting including overnight summer camps are **not** countable toward the 22-day minimum requirement.
4. Countable service days **may** include:
  - o Day of admission and day of discharge to a hospital, nursing home, ICF or other certified, licensed or government funded residential setting in cases where on those days IRA staff deliver and document residential habilitation services to the resident at the IRA.
  - o Days when IRA staff deliver and document residential habilitation services to a resident(s) who is away from the IRA for purposes such as vacations and visits with family or friends. Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Only 14 such days may be considered countable in a calendar month. Documentation must clearly state the location of this off-site service delivery.
  - o Days when all residents of the IRA are relocated due to emergency conditions or other circumstances reported to and approved by the DDSO/NYCRO and DQA. (It must be necessary to relocate the residents to preserve their health and safety.) Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Documentation must clearly state the location of this off-site service delivery.

**To bill a half month for any resident:**

1. The resident must be enrolled in the provider's supervised IRA program for a minimum of 11 days in a calendar month. "Enrollment" is defined as the time period commencing with the day of admission, up to and including the day of discharge.
2. The IRA staff must deliver and document a minimum of 11 separate days of face to face residential habilitation services, known as "countable service days", in accordance with the resident's ISP and Residential Habilitation Plan. A countable service day requires documentation of at least one residential habilitation staff service or action.
3. Days in a hospital, nursing home, ICF or other certified, licensed or government funded residential settings including overnight summer camps are **not** countable toward the 11-day minimum requirement.

4. **Countable service days may include:**

- Day of admission and day of discharge to a hospital, nursing home, ICF or other certified, licensed or government funded residential setting in cases where on those days IRA staff deliver and document residential habilitation services to the resident at the IRA.
- Days when IRA staff deliver and document residential habilitation services to a resident(s) who is away from the IRA for purposes such as vacations and visits with family or friends. Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Only 7 such days may be considered countable in a calendar month. Documentation must clearly state the location of this off-site service delivery.
- Days when all residents of the IRA are relocated due to emergency conditions or other circumstances reported to and approved by the DDSO/NYCRO and DQA. (It must be necessary to relocate the residents to preserve their health and safety.) Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Documentation must clearly state the location of this off-site service delivery.

Supportive IRAs

The unit of service for supportive IRA residential habilitation services is a calendar month. The provider determines whether minimum standards have been provided to bill a full month or a half-month for an individual resident based on the following:

**To bill a full month for any resident:**

1. The resident must be enrolled in the provider's supportive IRA program for a minimum of 22 days in a calendar month. "Enrollment" is defined as the time period commencing with the day of admission, up to and including the day of discharge.
2. The IRA staff must deliver and document a minimum of 4 separate days of face to face residential habilitation services, known as "countable service days", in accordance with the resident's ISP and Residential Habilitation Plan. **These countable service days must be provided at the IRA or initiated or concluded there. No more than 2 service**

days within a week are countable toward the 4-day minimum. A countable service day requires documentation of at least one residential habilitation staff service or action.

3. **Countable service days may include:**

- Day of admission and day of discharge to a hospital, nursing home, ICF or other certified, licensed or government funded residential setting in cases where on those days IRA staff deliver and document residential habilitation services to the resident at the IRA.
- Days when all residents of the IRA are relocated due to emergency conditions or other circumstances reported to and approved by the DDSO/NYCRO and DQA. (It must be necessary to relocate the residents to preserve their health and safety.) Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Documentation must clearly state the location of this off-site service delivery.

**To bill a half month for any resident:**

1. The resident must be enrolled in the provider's supportive IRA program for a minimum of 11 days in a calendar month. "Enrollment" is defined as the time period commencing with the day of admission, up to and including the day of discharge.
2. The IRA staff must deliver and document a minimum of 2 separate days of face to face residential habilitation services, known as "countable service days", in accordance with the resident's ISP and Residential Habilitation Plan. **These countable service days must be provided at the IRA or initiated or concluded there.** No more than one service day within a week is countable toward the 2-day minimum. A countable service day requires documentation of at least one residential habilitation staff service or action.
3. **Countable service days may include:**
  - Day of admission and day of discharge to a hospital, nursing home, ICF or other certified, licensed or government funded residential setting in cases where on those days IRA staff deliver and document residential habilitation services to the resident at the IRA.
  - Days when all residents of the IRA are relocated due to emergency conditions or other circumstances reported to and approved by the DDSO/NYCRO and DQA. (It must be necessary to relocate the residents to preserve their health and safety.)

Such days are countable only when staff regularly assigned to the resident's IRA deliver and document services that are similar in scope, frequency and duration to the residential habilitation services typically delivered to the resident at the IRA. Documentation must clearly state the location of this off-site service delivery.

### **Required Actions:**

IRA residential habilitation service note documentation must include the following:

### **Required Elements**

1. Consumer's name and Medicaid number ("CIN"). (Note that the "CIN" need not be included in daily documentation; rather it can appear in the consumer's ISP or Residential Habilitation Plan).
2. Identification of category of waiver service provided (i.e. IRA residential habilitation).
3. A description of the individualized service provided by staff, which is based on the person's Residential Habilitation Plan (e.g. a staff person documents that she "taught the person how to shop independently").
4. The consumer's response to the service (e.g. "the consumer was able to make his own purchase at the store"). (At a minimum, the consumer response must be documented in a monthly summary note. A provider may choose to include the consumer response more frequently, e.g. daily.)
5. The date the service was provided.
6. The primary service location (e.g. North Main Street IRA).
7. Verification of service provision by the staff person delivering the service (initials are permitted, if a "key" is provided which identifies the title, signature and full name associated with the staff initials).
8. The signature and title of the staff person writing the note.
9. The date the note was written

### **Acceptable Formats for the Service Note Supporting a Provider's Billing Submittal:**

Attached to this Administrative Memorandum are sample service note formats that conform to the required elements stated above. Attachment B is a sample daily narrative note and Attachment C is a daily checklist with a monthly summary note.

### **Attachment B – Daily Narrative Note Format**

If the daily narrative note format is selected, the documentation can be completed in one of two ways. 1) Daily narrative note describes the staff service or action and the resident's response to

the service delivery or 2) Daily narrative note describes staff service or action only. If this second format is selected, a monthly summary note addressing the consumer's response to services is required. The daily narrative note must be written by the staff person who provides the service or, if written by another staff person, must include the verification of service delivery by staff who actually delivered the service (see #7 of Required Elements).

**Attachment C – Daily Checklist with Monthly Summary Note Format**

If the checklist format is chosen, a monthly summary note, which includes the resident's response to service, must be completed.

**YOU MAY USE EITHER OF THESE FORMATS OR DEVELOP YOUR OWN SO LONG AS IT ENCOMPASSES ALL OF THE REQUIRED ELEMENTS LISTED ABOVE.**

**Other Documentation Required:** In addition to the service note(s) supporting each monthly IRA residential habilitation claim, your agency must maintain the following documentation:

- A copy of the consumer's ISP covering the time period of the claim developed by the consumer's Medicaid Service Coordination (MSC) or Plan of Care Support Services (PCSS) service coordinator. The ISP must specify the category of waiver service that your agency is providing (i.e. residential habilitation) and must designate your agency as the provider of the service. Further, for the service you are providing, the ISP must specify a service effective date for IRA residential habilitation that is on or before the first date of service your agency bills.
- The Residential Habilitation Plan covering the time period of the claim developed by your agency. The Residential Habilitation Plan is attached to the person's ISP. For supportive IRAs, the Residential Habilitation Plan must state the number of service visits residential habilitation staff will provide to meet the consumer's individualized need. This service visit number can be expressed as a range.

**Documentation Retention:** All documentation specified above, including ISPs, Residential Habilitation Plans, and daily service documentation, must be retained for a period of at least six years from the date of the service billed.

**Notification:** Effective with services delivered on or after July 1, 2002, OMRDD will review IRA Residential Habilitation service claims utilizing the service documentation requirements set forth in this Administrative Memorandum.

For additional information on the documentation requirements, contact Ms. Carol Metevia, Director of Medicaid Standards and Control at (518) 408-2096 or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

August 1, 2002

Page 8 of 8

cc: Provider Associations  
DDSO Directors  
Helene DeSanto  
Kathy Broderick  
Peter Pezzolla  
Carol Metevia  
Kevin O'Dell



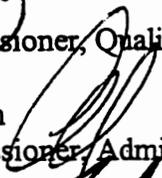
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**Administrative Memorandum - #2002-02**

**To:** Executive Directors of Agencies providing Supported Employment Services  
Executive Directors of Agencies providing Medicaid Service Coordination

**From:** Jan Abelseth   
Deputy Commissioner, Quality Assurance

Alden B. Kaplan   
Deputy Commissioner, Administration and Revenue Support

Gary Lind   
Director, Policy, Planning and Individualized Initiatives

**Subject:** Supported Employment Service Delivery and Documentation Requirements

**Date:** September 17, 2002

**Suggested Distribution:**

Program/Service Staff  
Quality/Compliance Staff  
Billing Department Staff  
MSC Service Coordinators

**Purpose:** This is to review the service delivery and documentation requirements for Supported Employment services delivered on or after October 1, 2001. These criteria apply to Supported Employment services rendered to Home and Community Based Service (HCBS) waiver enrolled individuals as well as to non-enrolled individuals. In addition to the requirements that became effective October 1, 2001, **a policy change on the location of service visits to employed individuals will go into effect on October 1, 2002.** This change is addressed in the New Policy on Service Delivery Location and Supported Employment Standards sections below. The service documentation requirements set forth in this Administrative Memorandum supersede fiscal audit service documentation requirements addressed in The Key to Individualized Services (1997), OMRDD's HCBS waiver policy manual. Quality service standards remain the same.

**Background:** Title 14 of the Official Compilation of Codes, Rules and Regulations of the State of New York Part 635-10.5 includes requirements applicable to supported employment services. Effective October 1, 2001, the regulation was changed so that reimbursement would be based on a monthly fee. Prior to the new regulation, reimbursement was based on an hourly fee.

The federal Centers for Medicare and Medicaid Services' (CMS) HCBS Waiver Review Protocol lists elements that must be included in the documentation of HCBS Medicaid payment claims. Based on the federal listing, this OMRDD administrative memorandum provides clarifying information on the required components of acceptable service documentation for Supported Employment Services.

Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York, Section 504.3 states that by enrolling in the Medicaid Program, "the provider agrees ... to prepare and to **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, such as OMRDD.

#### **New Policy on Service Delivery Location:**

On October 1, 2002, a new policy will take effect that requires that supported employment staff provide a minimum of two face-to-face documented services per month at the consumer's work site. Current policy requires that employed consumers receive a minimum of two face-to-face services per month from supported employment staff, but only one of these services must be provided at the consumer's work site. This policy change has been instituted for the following reasons: (1) to maintain consistency with requirements of other New York state agencies that provide supported employment funding; (2) to maintain consistency with the federal regulations pertaining to supported employment; (3) to reduce confusion in the field; and (4) to focus the supported employment service on job site issues. This change in policy is also consistent with OMRDD requirements prior to the October 1, 2001 supported employment conversion.

In rare situations, if the employed individual does not want the job coach to visit him/her at the work site, the supported employment agency can request a waiver from the work-site visit. The agency must send the request to the DDSO Supported Employment Coordinator stating the reason the consumer does not want the job coach at the work site, as well as identifying the supports and services that will be provided to assist the consumer in achieving his/her valued outcomes. The DDSO will determine if the waiver will be granted. If a waiver is granted, the supported employment provider must maintain a copy of the waiver in the consumer's record.

**Supported Employment Standards:**

The unit of service for Supported Employment Services is a calendar month.

Requirements for reimbursement depend on the employment status of the consumer:

- 1) To bill a month for an eligible **employed** consumer, the supported employment staff must render at least **two services provided face-to-face** with the consumer on separate days as specified in the consumer's Supported Employment Plan, and if required, the ISP. These face-to-face services must be documented and must be provided at the consumer's job site unless a written waiver has been granted by the DDSO.
- 2) To bill a month for an eligible consumer who doesn't have a job anytime during the month, the provider must actively engage in preparatory and placement activities leading to competitive employment or reemployment. The supported employment staff must render, on separate days, at least **four** such documented supported employment services, as specified in the Supported Employment Plan and if required, the ISP. At least **two** of these services by supported employment staff must be delivered in **face-to-face** contacts with the consumer.

**Special Notes:**

- A) Only one provider of supported employment services may claim for a service fee for an eligible person in a given calendar month.
- B) Reimbursement is contingent upon OMRDD's prior approval of HCBS waiver supported employment service to the person and documentation that the service is provided in accordance with the consumer's ISP and Supported Employment Plan.

**Service Documentation Requirements:**

Service documentation is necessary, at a minimum, for each of the services required for monthly billing. Documentation of services delivered must include the following required elements:

1. Consumer's name and Medicaid number (CIN). (Note that the CIN need not be included in daily documentation, rather it can appear in the consumer's Supported Employment Plan).
2. Identification of category of waiver service provided (i.e. Supported Employment).
3. **A description of the individualized service provided by supported employment staff**, which is based on the person's Supported Employment Plan (e.g. a staff person documents that she "instructed the person how to answer common job interview questions").

4. A statement regarding whether the service was delivered in a “face-to-face” contact with the consumer.
5. The consumer’s response to the service (e.g. “The staff person documents that based on the staff person’s instructions on answering common interview questions, the consumer was successful in her job interview.”). At a minimum, the consumer response must be documented in a monthly summary note. However, a provider may choose to include the consumer response each time a supported employment service is rendered.
6. The date the service was provided.
7. The primary service location (e.g. Madison Avenue Price Chopper).
8. Verification of service provision by the supported employment staff person delivering the service.
9. The signature and title of the staff person writing the note.
10. The date the note was written. (Medicaid rules require that the note must be contemporaneous to the service provision.)

Note: If the consumer experiences a significant life change, there should also be a note in the record assessing the impact of this change, any changes to valued outcomes, etc.

**General Documentation Requirements:** In addition to the service notes supporting each monthly Supported Employment claim, the supported employment agency must maintain the following documentation:

- For consumers receiving MSC and/or enrolled in the HCBS waiver, a copy of the consumer’s ISP, covering the time period of the payment claim, developed by the consumer’s Medicaid Service Coordination (MSC) or Plan of Care Support Services (PCSS) service coordinator. The ISP must include the following elements:
  1. The category of waiver service provided (i.e. Supported Employment Service) and identification of the supported employment agency delivering the service as provider of the service.
  2. Valued Outcome of the person receiving services (i.e. the person’s objective).
  3. Frequency and duration. The ISP should specify that the frequency of supported employment is “monthly” and the duration is “ongoing.”
  4. The effective date for Supported Employment Services (i.e. the date the consumer was enrolled in Supported Employment Services). This date must be on or before the first date of service that the supported employment agency bills for supported employment services.
- The **Supported Employment Plan** developed by the supported employment agency. The plan must cover the time period of the payment claim. For consumers requiring an ISP, the Supported Employment Plan is attached to the person’s ISP. The following elements must be included:

1. The category of waiver service provided (i.e. Supported Employment Service) and designation of the agency providing the supported employment service as provider of the service.
2. Valued Outcome of person receiving services (same as in ISP).
3. Frequency, duration, and effective date (same as in ISP).
4. Review Date. (The Supported Employment Plan must be reviewed every six months.)
5. Individualized Range of Service Frequency (e.g., for an employed consumer supported employment staff will provide from 2 to 8 services during the month.)
6. Locations where the service will be provided.
7. Description of the individualized supported employment services.
8. Safeguards to be taken by the provider to ensure person's health and safety if necessary.
9. Signature and title of the supported employment staff person writing the plan and the date the plan was written or updated

**Documentation Retention:** All documentation specified above, including ISPs, Supported Employment Plans, and daily service documentation, must be retained for a period of at least six years from the date of the service billed.

**Notification:** For those services delivered on or after October 1, 2001, OMRDD is reviewing supported employment service claims utilizing the service delivery and documentation requirements contained in this administrative memorandum. For services delivered on or after October 1, 2002, the location of service provision for employed consumers must be in compliance with the new policy discussed in the New Policy on Service Delivery Location and Supported Employment Standards sections.

For additional information, contact Ms. Carol Metevia, Director of Medicaid Standards and Control at (518) 408-2096 or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

Cc: DDSO Directors  
DDSO Supported Employment Coordinators  
Provider Associations  
Helene DeSanto  
Kathy Broderick  
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Carol Metevia  
Kevin O'Dell  
Eugenia Haneman



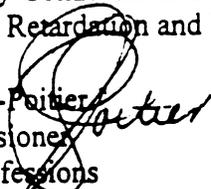


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**Administrative Memorandum - #2003-01**

**To:** Directors of Developmental Disabilities Services Offices  
Executive Directors of Agencies Providing Residential Services

**From:** Helene DeSanto   
Executive Deputy Commissioner  
Office of Mental Retardation and Developmental Disabilities

Johanna Duncan-Poitier   
Deputy Commissioner  
Office of the Professions  
New York State Education Department

**Subject:** Registered Nursing Supervision of Unlicensed Direct Care Staff in Residential Facilities  
Certified by the Office of Mental Retardation and Developmental Disabilities

**Date:** January 2003

**Suggested Distribution:**

Registered Professional Nurses  
Licensed Practical Nurses  
Quality Compliance Staff  
Program/Direct Care Staff  
Administrative Staff

**Purpose**

This administrative memorandum has been developed to define the appropriate level of supervision, by a registered professional nurse, that is to be provided to unlicensed direct care staff who perform tasks or activities commonly identified as nursing procedures pursuant to § 6908(1)(b) of New York State Education Law.

## **Applicability**

This directive applies to all certified community-based residences, with the exception of family care homes, where two or more consumers receive services, including Intermediate Care Facilities (ICFs), Community Residences (CRs), and Individual Residential Alternatives (IRAs). This directive and the provisions of §6908(1)(b) of the New York State Education Law do not apply to non-certified residential settings.

## **Definitions**

A Registered Professional Nurse (RN) shall be responsible for the supervision of unlicensed direct care staff in the performance of nursing tasks and activities. It is the responsibility of the employing agency to ensure that all staff is adequately trained regarding the elements of clinical nursing supervision, and the difference between clinical nursing supervision and administrative supervision.

Adequate nursing supervision is the provision of guidance by an RN for the accomplishment of a nursing procedure, including:

- initial training of the task or activity; and
- periodic inspection of the actual act of accomplishing the task or activity.

The amount and type of nursing supervision required will be determined by the RN responsible for supervising the task or activity, and will depend upon:

- the complexity of the task;
- the skill, experience and training of the staff; and
- the health conditions and health status of the consumer.

## **Frequency of Visits**

The frequency of visits to certified community-based residences with two or more consumers shall be the discretion of the RN responsible for supervision but in no case shall visits occur less frequently than once a week.

## **Professional Nursing Availability**

There shall be an RN available to unlicensed direct care staff 24 hours a day, 7 days a week. The RN must be either on site or immediately available by telephone. The residence RN or, during off-hours, the RN on-call will be immediately notified of changes in medical orders for a consumer and/or of change in a consumer's health status.

## **Plan of Nursing Services**

The RN is responsible for developing an individualized plan for nursing services for any consumer who requires nursing care, including those who require medication administration for diagnosed medical conditions. Such plans will be updated at least annually or whenever there is a significant change in the consumer's condition.

The RN shall document that direct care staff have been educated about the chronic conditions and related health care needs of each consumer in their care.

The RN shall ensure that there is a consumer specific medication sheet for each medication that is administered. This sheet shall include all of the information required by 14 NYCRR §633.17(a)(17)(iii).

### **Nursing Procedures**

It shall be the responsibility of the Registered Professional Nurse to determine which nursing procedures unlicensed direct care staff will be allowed to perform, and which unlicensed staff will be allowed to perform them. The Registered Professional Nurse shall exercise professional judgement as to when delegation is unsafe and/or not in the consumer's best interest.

When making a decision regarding a nursing task or activity, the RN shall assess the following:

- complexity of the task;
- condition/stability of the consumer; and
- training, skill and experience of the staff involved, including relevant factors related to the individual's ability to safely provide nursing services.

In no case will an RN allow direct care staff to perform a nursing procedure that is outside the scope of practice of an LPN.

### **Training**

RNs who do not have previous experience in the field of mental retardation/developmental disabilities (MR/DD) nursing will be required to complete an orientation for registered nurses in MR/DD nursing within three months of being hired.

It is the responsibility of the RN to provide initial and on-going training to unlicensed direct care staff in all nursing tasks and/or functions that they will perform. The RN must periodically review that the performance of unlicensed staff is consistent with standards of care and training.

Medication administration, tube feeding and diabetic care shall be taught utilizing a standard curriculum approved by the Office of Mental Retardation and Developmental Disabilities (OMRDD).

Diabetic care shall be taught by either:

- A Certified Diabetic Educator (CDE). In those instances where the CDE is not a RN, the administration of insulin shall be taught by an RN;

OR

- An RN who has successfully completed an OMRDD approved train-the-trainer course to teach diabetes care to unlicensed direct care staff. Approval to teach diabetic care to unlicensed direct care staff shall be for a period of one year. Continued approval will be dependent upon completion of annual knowledge/skill maintenance training.

Unlicensed direct care staff will be separately certified for medication administration, tube feeding and insulin administration and shall be recertified on an annual basis.

Resident managers who have not previously completed the didactic portion of the OMRDD-approved medication administration curriculum shall be required to do so. However, residence managers will not be certified to administer medication unless they are also designated as "staff providing direct care services" as defined in 14 NYCRR §633.99 [See Attachment]

It is the intent of the regulation that the staff not only has the responsibility for direct care in the job description, but that they are also actually providing direct hands-on care. It is recognized that many unit supervisors and/or house managers do routinely provide direct care to consumers. Each agency must determine which supervisors and/or house managers within their agency meet the letter, the spirit and the intent of the regulation.

### **Clinical Evaluations**

The RN shall conduct annual clinical performance evaluations for unlicensed direct care staff for procedures that include but are not limited to medication administration. This evaluation shall become part of the employee's annual performance evaluation.

### **Staffing Ratios**

The following items shall be considered when establishing an RN/consumer ratio for RNs assigned to provide nursing services in community based residences:

- the health status/stability of the consumers;
- the type of residential facility;
- the actual number of direct care staff, both full and part time, who are to be trained and supervised;
- the number of Licensed Practical Nurses to be supervised;
- the number of certified residences involved, their geographic location and proximity to each other and proximity to health care providers; and
- the degree of additional nursing services provided by external nursing agencies.

Based on the evaluation of these factors, the provider agency shall establish a registered nurse/consumer ratio that ensures consistently adequate nursing supervision. In no instance shall this ratio exceed on full time equivalent of an RN to 50 consumers (1:50). Some ratios will need to be significantly less than this based upon evaluation of the above factors.

RN/consumer ratios shall be re-evaluated within one week if there are any significant changes in any of the factors listed above and RN assignments adjusted accordingly.

If an RN is acting as the supervising nurse for the agency and also has responsibility for one or more residences, only that portion of her/his time that is devoted to the residences may be used in calculating the ratio.

**Effective Date**

May 1, 2003

**Contact Information**

For additional information, contact Kathleen Keating, RN, MSN, CNP, Director of Health Services, NYS OMRDD at 518-473-9697 or by e-mail at [Kathleen.Keating@omr.state.ny.us](mailto:Kathleen.Keating@omr.state.ny.us).

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Kathleen Keating

## ADM #2003-01

### Attachment

#### 14 NYCRR SECTION 633.17(a)(17)(iii)

(iii) For the safety of the people residing in or attending a facility and as a support to those staff who have medication administration related responsibilities, there shall be information specific to each person on all medications to be administered to that person while at or under the supervision of the facility and its staff. The sponsoring agency shall ensure maintenance of this information for people in family care homes and provide the information to the family care provider. For each medication a person is taking, this information shall include:

- (a) name of person taking the medication;
- (b) name of medication;
- (c) directions with regard to correct dose, form, method/route of administration, time of administration;
- (d) start and stop dates, if applicable;
- (e) expected therapeutic effects for the person taking the medication;
- (f) possible side effects to the person taking the medication; and
- (g) name of prescribing, ordering or approving practitioner.

#### 14 NYCRR SECTION 633.99

(cx) Services, staff providing direct care. For purposes of medication administration, an employee who, by job description, is responsible for providing the day-to-day hands-on care, training, guidance, direction, assistance, support, etc. to persons in a facility. Employees hired to provide professional or any other services cannot be designated as providing "direct care services."

**MEMORANDUM OF UNDERSTANDING  
BETWEEN THE  
NEW YORK STATE OFFICE OF MENTAL RETARDATION  
AND DEVELOPMENTAL DISABILITIES AND  
THE NEW YORK STATE EDUCATION DEPARTMENT  
REGARDING REGISTERED NURSING SUPERVISION  
OF UNLICENSED DIRECT CARE STAFF  
IN RESIDENTIAL FACILITIES CERTIFIED BY THE  
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES**

WHEREAS, the Office of Mental Retardation and Developmental Disabilities (OMRDD) is responsible for the delivery of services for individuals with developmental disabilities throughout New York State; and

WHEREAS, the New York State Education Department (SED) is responsible for issuing licenses to registered professional nurses and licensed practical nurses; and

WHEREAS, OMRDD and SED wish to define the appropriate level of supervision that is to be provided by registered professional nurses to unlicensed OMRDD direct care staff who perform tasks or activities commonly identified as nursing procedures pursuant to §6908(1)(b) of the New York State Education Law;

NOW, THEREFORE, OMRDD and SED hereby agree as follows:

1. The nursing supervision administrative memorandum which is attached hereto establishes the appropriate level of supervision that is to be provided by registered professional nurses to unlicensed OMRDD direct care staff who perform tasks or activities commonly identified as nursing procedures pursuant to §6908(1)(b) of the New York State Education Law.
2. OMRDD shall request approval from the Governor's Office of Regulatory Reform to add a provision to the regulations set forth in 14 NYCRR which incorporates the attached nursing supervision administrative memorandum by reference.
3. OMRDD shall confer with designated representatives of SED regarding public comments and suggestions made by the Governor's Office of Regulatory Reform relating to such regulatory proposal.
4. OMRDD shall incorporate review of adherence to the attached administrative memorandum within its routine survey of OMRDD certified community-based residential facilities.

5. The attached administrative memorandum may be amended only in writing by mutual agreement of designated representatives of the undersigned parties.

Dated: 2/10/03

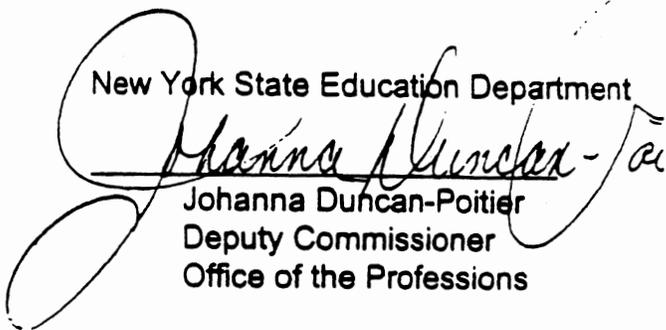
New York State Office of Mental  
Retardation and Developmental  
Disabilities



Helene DeSanto  
Executive Deputy Commissioner

Dated: 2/18/03

New York State Education Department



Johanna Duncan-Poitier  
Deputy Commissioner  
Office of the Professions



STATE OF NEW YORK  
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

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**Administrative Memorandum - #2003-02**

**To:** Executive Directors of Agencies Authorized to Provide Plan of Care  
Support Services  
DDSO Directors

**From:** Gary Lind   
Director, Policy, Planning and Individualized Initiatives

**Subject:** Plan of Care Support Services

**Date:** March 5, 2003

**Suggested Distribution:**

Medicaid Service Coordinators and supervisors  
Agency managers  
Billing Department staff

**Purpose:**

This administrative memorandum will define Plan of Care Support Services (PCSS), a Home and Community-Based waiver service (HCBS), and explain how to use the service properly.

**Background:** Each person enrolled in the HCBS waiver must have an Individualized Service Plan (ISP) developed and then reviewed at least every six months. Typically this requirement is met through the receipt of Medicaid Service Coordination (MSC), which is a Medicaid State Plan service. MSC is an ongoing service requiring monthly face-to-face contact between the consumer and the service coordinator. Some consumers and families requested the opportunity to coordinate their ISP without the month-to-month oversight of a professional service coordinator. In response, PCSS was developed. Effective June 1, 2000, OMRDD introduced PCSS as an alternative for maintaining the Individualized Service Plan (ISP). Title 14 of the Official Compilation of Codes, Rules and Regulations of the State of New York, section 635-10.5(a) states the service standards and requirements for PCSS.

### **PCSS Definition:**

PCSS providers (a) assist consumers to review and update the ISP in accordance with applicable New York State regulations, federal guidelines and OMRDD policy, and (b) ensure the annually required level of care (LOC) determination is completed within one year of the previous determination. PCSS is delivered by a qualified Medicaid Service Coordinator.

In order to continue to meet the ISP and level of care eligibility requirements in New York State's waiver agreement with the Center for Medicare and Medicaid Services (CMS), consumers enrolled in the HCBS Waiver who choose not to receive MSC must receive Plan of Care Support Services contingent on official approval by the Developmental Disabilities Service Office (DDSO) or New York City Regional Office (NYCRO). **Prior to receiving PCSS, a consumer enrolled in the HCBS waiver must have received at least three months of MSC, with the exception of Early Intervention enrollees.**

PCSS is a service that produces or updates the ISP. PCSS is a justified service when it is used for the purpose of coordinating other Home and Community-Based Services (HCBS). Therefore, PCSS may only be authorized when the consumer receives at least one other waiver service that meets a specific need.

For a person with verifiable comprehensive and ongoing service coordination needs, who is not enrolled in the HCBS Waiver, but wishes to receive PCSS for purposes of ISP development, PCSS may be provided as a "Non-Waiver Enrolled (NWE)" or "mirrored service." The individual must be authorized for "mirrored" PCSS by the DDSO or NYCRO.

### **Children in the Early Intervention Program**

Children participating in the Early Intervention (EI) Program receive an IFSP (Individual Family Service Plan) for their EI services, but they must also have an ISP if they are receiving an HCB service at the same time. Because EI children receive service coordination from the EI program, they are therefore ineligible for MSC. It is an approved practice for these children to receive PCSS and another HCB waiver service. Additionally, some families request PCSS alone to allow a seamless transition into HCBS either during or following their participation in the EI program. In such instances, children should receive PCSS when it is expected that they will receive another HCB waiver service within a year of waiver enrollment.

### **Service Coordinator tasks:**

Service coordinators providing Plan of Care Support Services will be responsible for the following tasks:

- (1) Maintaining a current ISP in consultation with the consumer, and completing a review at least every six (6) months. **This review must include a face-to-face contact with the consumer at the consumer's residence or at an alternate site mutually agreed to by the consumer and the service coordinator.** The consumer is responsible for contacting the service coordinator to initiate any changes to the ISP should they be needed prior to the next review. ISPs will be based on consumer choice, consumer capabilities, appropriate professional consultation, and the professional judgment of the service coordinator.
- (2) Making whatever contacts with the consumer's advocate, if any, and major service providers necessary to accurately review and update the ISP if needed. The consumer, his/her family or advocate may request a review or voice an objection to the ISP, consistent with 14 NYCRR section 633.12.
- (3) Assuring that necessary safeguards have been identified to protect the health and welfare of the consumer.
- (4) Assuring that the ICF/MR level of care eligibility determination is completed annually for all HCBS enrollees.
- (5) Maintaining a record that includes all required waiver enrollment documentation, clinical assessments, the ISP (and attachments) and Plan of Care Support Service notes. The ISP must be retained by the PCSS provider agency, with copies provided to the consumer, advocate and primary service providers.
- (6) Notifying the DDSO/NYCRO if the consumer is no longer eligible for waiver services.
- (7) Initiating a re-enrollment in Medicaid Service Coordination if circumstances warrant, such as (a) the consumer's health or safety are compromised, (b) the plan can not address the needs or outcomes, and/or (b) the consumer chooses to receive Medicaid Service Coordination.

### **PCSS Provider Qualifications:**

Plan of Care Support Services shall be delivered by an authorized vendor of Medicaid Service Coordination. The provider must also have an HCBS waiver provider agreement with OMRDD and NYS DOH for PCSS.

### **Service Coordinator Qualifications:**

Any service coordinators providing Plan of Care Support Services must meet the requirements of either clause (a) or (b) below:

- (a) The service coordinator:**
  - (1) Provided OMRDD sponsored Comprehensive Medicaid Case Management or HCBS Waiver service coordination prior to 2/29/00; and
  - (2) Attends, annually, fifteen hours of professional development.
  - (3) Has completed an OMRDD-approved core service coordination training program.
  
- (b) The service coordinator:**
  - (1) Has at least an associates degree, or equivalent accredited college credit hours, in a health or human services field or be a registered nurse; and
  - (2) Has at least one year experience working with persons with developmental disabilities or at least one year experience providing service coordination to any population; and
  - (3) Has completed an OMRDD-approved core service coordination training program; and
  - (4) Attends, annually, fifteen hours of professional development.

### **Documentation Requirements:**

The federal CMS HCBS Waiver Review Protocol lists elements that must be included in the documentation of HCBS Medicaid payment claims. Based on the federal listing, this OMRDD administrative memorandum provides clarifying information on the required components of acceptable service documentation for Plan of Care Support Services.

Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York, Section 504.3 states that by enrolling in the Medicaid Program, "the provider agrees...to prepare and to 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.

### **PCSS Service Note Required Elements**

The service coordinator must record a narrative note at least every six (6) months. The note must be entered in the Service Coordinators Notes section of the primary record no later than the fifteenth (15<sup>th</sup>) day of the month following the record review. The PCSS service note documentation must include the following:

1. Consumer's name and Medicaid number ("CIN") (Note that the "CIN" need not be included in the service note documentation, rather it can appear in the consumer's ISP).
2. Identification that this note pertains to Plan of Care Support Services.
3. A narrative statement that (a) verifies that a record review was held, (b) verifies that the ISP has been updated and states what changes were made, if any, to the plan, (c) states the service coordinator's recommendation for the person to either continue to use PCSS or to refer the person to reinstate monthly MSC services and (d) verifies that a face-to-face contact was made with the consumer, including the date.
4. The service coordinator's name, signature and title.
5. The date the note was written. (Medicaid rules require that the note must be contemporaneous to the service provision.)

### **Documentation Retention**

In addition to the service notes supporting each PCSS claim, the PCSS provider must retain the consumer's ISP covering the time period of the PCSS payment claim. The ISP, Section 2, HCB Waiver Services, must identify PCSS and include the following elements:

- The category of waiver service provided (i.e., Plan of Care Support Services).
- The name of the PCSS provider.
- The frequency (six months) and the duration (ongoing) of PCSS.
- The effective date for PCSS. The effective date must be on or before the first date of service that your agency bills for PCSS.

All documentation specified above, including ISPs, Level of Care and service documentation, must be retained for a period of at least six years from the date of the service billed.

**Unit of Service:**

The unit of service for Plan of Care Support Services is six (6) months. The agency providing PCSS may bill for the service no more frequently than once every six months. Therefore, the ISP must state that the frequency of PCSS is six (6) months.

Questions regarding PCSS should be directed to Kevin O'Dell at 518-474-5647 or e-mail at [kevin.odell@omr.state.ny.us](mailto:kevin.odell@omr.state.ny.us)

cc:	Provider Associations	Kathy Broderick
	Peter Pezzolla	Helene Desanto
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**ADMINISTRATIVE MEMORANDUM - #2003-03**

**TO: Executive Directors of Agencies Authorized to Provide:**

- X Residential Habilitation Services**
- X Day Habilitation Services**
- X Prevocational Services**
- X Supported Employment Services**
- X Medicaid Service Coordination**

**DDSO Directors**

**FROM: Gary Lind, Director**   
**Policy, Planning and Individualized Initiatives**

**Jan Abelseth, Deputy Commissioner**   
**Division of Quality Assurance**

**SUBJECT: HABILITATION PLAN REQUIREMENTS**

**DATE: December 5, 2003**

**Suggested Distribution:**

Habilitation Services Staff  
Agency Managers  
Billing Department Staff  
Medicaid Service Coordinators and Supervisors

**Purpose:**

This Administrative Memorandum will define the Habilitation Plan and state the elements that must be in all Habilitation Plans for both Home and Community-Based Services (HCBS) Waiver enrollees and non-enrollees that receive a Habilitation Service funded by OMRDD.

Habilitation Services are:

- (a) Residential Habilitation in approved sites: Individualized Residential Alternative (IRA), Community Residence (CR), At-home, and Family Care;
- (b) Day Habilitation;
- (c) Prevocational Services; and
- (d) Supported Employment (SEMP).

ADMINISTRATIVE MEMORANDUM #2003-03

Habilitation Plan Requirements

December 5, 2003

The memorandum will also provide guidelines about the monthly summary note documentation and quality features of the Habilitation Plan.

There are standards for service quality and standards for service billing. Habilitation service providers must meet the documentation requirements in this administrative memorandum to justify habilitation service billing. Service quality standards are based on the requirements in this memorandum plus OMRDD Division of Quality Assurance Provider's Guide To the Non-ICF Survey Process (October, 2002) and The Key to Individualized Services - The Home and Community Based Services Waiver Provider Guide (OMRDD, 1997).

**Defining the Habilitation Service and Habilitation Plan:**

Habilitation Services are those supports and services that assist people to live successfully in their home, work at their jobs and participate in the community. Habilitation Plans describe what staff (the word "staff" in this memo includes family care providers) will do to help the person reach his or her valued outcome(s) that have been identified in the Individualized Service Plan (ISP). The ISP provides the authorization for delivering a particular Habilitation Service (e.g. Day Habilitation). Habilitation Services involve staff teaching a skill and/or helping the person, i.e., providing a support, and new experiences. The regulations that govern Habilitation Services are 14 NYCRR Parts 624, 633, 671, 686, and subpart 635-10.

**Habilitation Plan Requirements:**

The Habilitation Service Provider writes the Habilitation Plan. The ISP is written by the person's service coordinator as required under either Medicaid Service Coordination or Plan of Care Support Services. The Habilitation Plan describes the services and supports that will enable the person to pursue his/her valued outcome(s) stated in the ISP. The initial Habilitation Plan is written by the Habilitation Service Provider in collaboration with the person, their advocate and service coordinator. within 60 days of the start of the Habilitation Service and is forwarded to the service coordinator. Subsequent revised Habilitation Plans, which are also written by the Habilitation Service Provider, are given to the person's service coordinator no more than 30 days after either: (a) the six-month ISP review date, or (b) the Habilitation Service Provider makes a significant change in the Habilitation Plan as agreed upon by the person, their advocate and service coordinator.

**The Habilitation Plan Must Contain the Following Seven Elements:**

1. The person's (a) Name and (b) Medicaid Identification Number (CIN), if the person is a Medicaid enrollee.
2. The **Habilitation Service Provider agency name and type of Habilitation Service provided** (e.g., Day Habilitation). The Habilitation Service Provider may use a pre-printed format for this information. Absent pre-printed information, the Provider name and type of Habilitation service must be entered on the plan.
3. The **date on which the Habilitation Plan was last reviewed**. Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the Habilitation Service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least once every six months. It is recommended that the six-month review be conducted at the time of the ISP meeting arranged by the person's service coordinator. When the Habilitation Plan is reviewed at the ISP meeting, the Habilitation Plan review date will correspond to the ISP review meeting date. At least annually, the Habilitation Plan must be reviewed at the ISP meeting with the service coordinator, consumer, advocate, and with all other major service providers in attendance.
4. The person's **valued outcome(s)** that will be addressed through the Habilitation Service. The person's valued outcome(s) are specified in the ISP. The Habilitation Service is "authorized" only where the service relates to at least one of a person's valued outcomes. The Habilitation Plan writer uses these valued outcomes as a starting point for writing the Habilitation Plan and then goes on to describe the combination of skill acquisition, staff supports and exploration of new experiences that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes.
5. A description of the **services and supports** the Habilitation Service Provider staff will provide to the person. The services and supports that will be provided by the Habilitation staff are further described in the section of this memorandum titled "Quality Features of the Habilitation Plan."
6. The **safeguards** (health and welfare) that will be provided by the Habilitation Service Provider. The safeguards delineated in Section 1 of the ISP are used as the starting point for the Habilitation Service Provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff, as appropriate, must have knowledge of the person's safeguards.
  - a. Safeguards for persons receiving IRA Residential Habilitation are addressed in the individual's Plan of Protective Oversight in accord with 14 NYCRR Section 686.16. The individual's Plan of Protective Oversight is *attached* to the IRA Residential Habilitation Plan.

ADMINISTRATIVE MEMORANDUM #2003-03

Habilitation Plan Requirements

December 5, 2003

- b. For all other Habilitation Services (Residential Habilitation in Family Care, CRs and At Home; Day Habilitation; Prevocational Services; and Supported Employment) safeguards are *included* in the Habilitation Plan or the plan must reference other documentation that specifies the safeguards. *Information on the safeguards must be readily available to the Habilitation Service Provider staff.*

For example:

- i. A safeguard *included* in the Habilitation Plan for a person with exercise-induced asthma might state that he or she must use an inhaler prior to any physical activity.
- ii. The Habilitation Plan might reference the nutritional plan notebook located in the program office, which contains information on the individual's food allergies.

Either including the safeguards or referencing the safeguards is acceptable.

- c. As required in 14 NYCRR Part 633, the medication records stand-alone from the Habilitation Plan. The Habilitation Plan references the medication records as containing important health related information when applicable. If the Habilitation Service Provider is teaching the person to self-administer medication, that goal and methodology should appear in the Habilitation Plan.
- d. Providers of residential habilitation, including at-home services or services provided in IRAs, must have written procedures for providing back-up supports to consumers when the absence of the provider's regularly scheduled staff would pose a serious threat to the person's health or safety.

For certified IRAs, this information must be included in site-specific plans for protective oversight, and in individual plans for protective oversight as appropriate. For individuals receiving at-home residential habilitation, the information could be included in individual residential habilitation plans if appropriate, but minimally must be available in writing as part of the agency's policies and procedures.

7. The **printed name, signature and title** of the person who wrote the Habilitation Plan and the **date** it was written or revised.

**The Monthly Note:**

To support service claim documentation and quality services, the service provider must assure that at least monthly, or more frequently if the provider so chooses, a narrative note is written that: a) summarizes the implementation of person's Habilitation Plan, b) addresses the person's response to the services provided, and c) states any issues or concerns about the plan or the person.

**Service Claim Documentation:**

ADM-2002-01, ADM 2002-02, ADM 2003-04 and ADM 2003-05 describe service documentation requirements for billing. For all Habilitation Services, there must be documentation of individualized services that are drawn from the person's Habilitation Plan.

**Quality Features of the Habilitation Plan:**

A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan should address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, and exploration of new experiences. The strategies are discussed below. The Habilitation Service Provider, using professional judgment and in collaboration with the person and his/her service coordinator, decides which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new Habilitation Service staff to know what they must do to implement the person's Habilitation Plan. It should be noted that the Habilitation Plan provides strategies for habilitation service delivery and is not meant to identify each and every activity that occurs throughout the day.

1. **Skill Acquisition/retention** describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress periodically. The assessment and progress may be measured by either observation, interviewing staff or others that know the person well and/or by data collection.

Skill acquisition/retention goals should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, the Habilitation Service can be directed to skill retention.

2. **Staff Supports** are those actions provided by the habilitation staff when the person is not expected to independently perform a task without supervision that is essential to preserve the person's health or welfare, or to reach a valued outcome. Examples are assistance with personal hygiene or activities of daily living. Staff oversight of the person's health and welfare is also a part of the Habilitation Service (e.g., when staff accompany people in the community or provide first aid).
3. **Exploration of new experiences** is an acceptable component of the Habilitation Plan when based on an appropriate review by the Habilitation Service Provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. This trial and error process eventually enables the person to make informed choices and, consequently, to identify new valued outcomes that then become part of the ISP and the Habilitation Plan.

ADMINISTRATIVE MEMORANDUM #2003-03  
Habilitation Plan Requirements  
December 5, 2003

For additional information about the Habilitation Plan, please contact Mr. Kevin O'Dell, Director of Waiver Management, at (518) 474-5647 or via e-mail at [kevin.odell@omr.state.nv.us](mailto:kevin.odell@omr.state.nv.us).

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**ADMINISTRATIVE MEMORANDUM - #2004-01**

**TO:** Executive Directors of Agencies Authorized to Provide At-Home Residential Habilitation Services  
Executive Directors of Agencies Authorized to Provide Medicaid Service Coordination (MSC)  
DDSO Directors

**FROM:** Jan Abelseth, Deputy Commissioner  
Division of Quality Assurance

Gary Lind, Director  
Policy, Planning and Individualized Initiatives

James E. Moran, Interim Deputy Commissioner  
Division of Administration and Revenue Support

**SUBJECT:** AT-HOME RESIDENTIAL HABILITATION SERVICE DOCUMENTATION REQUIREMENTS

**DATE:** March 8, 2004

**Suggested Distribution:**

At-Home Residential Habilitation Program/Service Staff  
Quality/Compliance Staff  
Billing Department Staff  
MSC Service Coordinators and Service Coordinator Supervisors

**Purpose:**

This is to review the At-Home Residential Habilitation service documentation requirements that support a provider's claim for reimbursement. These service documentation criteria apply to At-Home Residential Habilitation services rendered to Home and Community Based Services (HCBS) waiver-enrolled individuals as well as to non-waiver enrolled individuals. Requirements set forth in this Administrative Memorandum supersede fiscal audit service documentation requirements addressed in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD, 1997). Quality service standards in The Key remain the same.

### **Background:**

18 NYCRR, Section 504.3(a) states that by enrolling in the Medicaid program, “the provider agrees...to prepare and to **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.” (emphasis added) It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for HCBS Waiver At-Home Residential Habilitation is in 14 NYCRR section 635-10.4(b)(1) and 635-10.5(b)(13)-(16)

### **At-Home Residential Habilitation Services:**

The billing unit of service for At-Home Residential Habilitation is a day, although the length of that day may vary by consumer. To bill for each day of service, At-Home Residential Habilitation staff must deliver and daily document at least one face-to-face individualized At-Home Residential Habilitation service for each continuous time period of At-Home Residential Habilitation delivered. For example, if At-Home Residential Habilitation is provided 7:00 a.m. – 9:00 a.m. and 4:00 p.m. – 6:00 p.m. on a given day, there must be documentation of at least one service for the 7:00 a.m. – 9:00 a.m. block of time and documentation of at least one service delivered for the 4:00 p.m. – 6:00 p.m. block of time. As part of the required contemporaneous daily service documentation, the provider must specify the number of service hours that were delivered on any day of service billed. In this example, there would be a total of four hours of service recorded. For information on annual service hour requirements and OMRDD audits of At-Home Residential Habilitation prices, refer to ADM #2004-02.

### **Service Documentation:**

**Medicaid rules require that service documentation be contemporaneous with the service provision**  
Required service documentation elements are:

1. Consumer’s name and Medicaid number (CIN) (Note that the CIN need not be included in daily documentation, rather it can appear in the consumer’s Residential Habilitation Plan)
2. Identification of category of waiver service provided (i.e. At-Home Residential Habilitation)
3. **A daily description of at least one face-to-face service provided by staff**, which is an individualized service based on the person’s Residential Habilitation Plan (e.g. the staff person documents that he/she “taught the consumer how to buy nutritious foods for his meals”)
4. The consumer’s response to the service (e.g. the staff person documents that “the consumer was able to select nutritious food items at the grocery store”) Note: at a minimum, the consumer response must be documented in a monthly summary note, though a provider may choose to include the consumer response more frequently, e.g. daily
5. The date the service was provided

6. The number of service hours delivered (also see ADM #2004-02 for information on annual service hour requirements)
7. The primary service location (i.e. consumer's residence)
8. Verification of service provision by the **At-Home Residential Habilitation staff person delivering the service** (Initials are permitted, if a "key" is provided which identifies the title, signature and full name associated with the staff initials)
9. The signature and title of the At-Home Residential Habilitation staff person documenting the service
10. The date the service was documented (must be contemporaneous with service provision)

The acceptable format for the service documentation supporting a provider's billing submittal is either a narrative note or a checklist/chart with an entry made contemporaneously for each day the At-Home Residential Habilitation service is delivered and billed.

#### Narrative Note Format

If the narrative note format is selected, the documentation can be completed in one of two ways:

1. A daily service note describing at least one face-to-face individualized service delivered by At-Home Residential Habilitation staff. The note does not include the consumer's response to the service. If this format is selected, a monthly summary note is required. This monthly note must summarize the implementation of the individual's Residential Habilitation Plan, address the consumer's response to the services provided and any issues or concerns; **OR**
2. A daily service note describing at least one face-to-face individualized service delivered by At-Home Residential Habilitation staff and the consumer's response to the service delivery. Additionally, at least one of the daily notes written during the month must summarize the implementation of the individual's Residential Habilitation Plan and address any issues or concerns.

#### Checklist / Chart Format

A provider may elect to use a checklist or chart to document at least one face-to-face individualized At-Home Residential Habilitation service delivered by At-Home Residential Habilitation staff each day service is delivered and billed. If this format is selected, a monthly summary note is also required. The monthly summary note must summarize the implementation of the individual's Residential Habilitation Plan; address the consumer's response to services provided and any issues or concerns.

**Both the Narrative Note and the Checklist/Chart formats must include all the Service Documentation elements listed above, including a description of at least one face-to-face individualized service provided by At-Home Residential Habilitation staff each day the provider bills At-Home Residential Habilitation.**

**Other Documentation Requirements:**

In addition to the service note(s) supporting the At-Home Residential Habilitation billing claim, your agency must maintain the following documentation:

- ✓ A record of service hours delivered on each day At-Home Residential Habilitation is billed.
- ✓ For the time period of the claim, a copy of the consumer's Individualized Service Plan (ISP) developed by the consumer's Medicaid Service Coordinator (MSC) or Plan of Care Support Service (PCSS) service coordinator. The ISP must specify the category of waiver service that your agency is providing (i.e. At-Home Residential Habilitation) and must designate your agency as the provider of the service. Further, the ISP must specify an effective date for At-Home Residential Habilitation that is on or before the first date of service for which your agency bills At-Home Residential Habilitation for the consumer.
- ✓ The Residential Habilitation Plan developed by your agency that conforms to the Habilitation Plan requirements found in ADM #2003 -03. The Residential Habilitation Plan must "cover" the time period of the At-Home Residential Habilitation service claim. Note that the consumer's Residential Habilitation Plan is attached to his/her ISP.

**Documentation Retention:**

All documentation specified above, including the ISP, 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.

For additional information on the documentation requirements or to request samples of documentation checklist formats, contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408 2096, or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

cc: Provider Associations  
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**MEMORANDUM**

**TO:** Executive Directors of Agencies Providing  
Medicaid Service Coordination/  
Plan of Care Support Services  
DDSO Directors

**FROM:** Jan Abelseth, Deputy Commissioner  
Quality Assurance   
Gary Lind, Director  
Policy, Planning and Individualized Initiatives   
James F. Moran, Interim Deputy Commissioner  
Administration and Revenue Support 

**DATE:** February 17, 2004

**SUBJECT:** OMRDD Advisory on Medicaid Service Coordination (MSC) and Plan of  
Care Support Services (PCSS) Service Coordinator ISP Responsibilities

**SUGGESTED DISTRIBUTION:**

MSC Service Coordinators  
MSC Supervisors  
PCSS Service Coordinators  
PCSS Supervisors

**PURPOSE:**

This Advisory addresses service coordinator Individualized Service Plan (ISP) responsibilities. The ISP must include a listing of all of a consumer's current authorized Home and Community Based Services (HCBS) waiver services with timely updates made when new services are added. Further, updated ISPs must be distributed to the consumer's HCBS waiver service providers. The importance of these ISP responsibilities was brought to our attention with a recent change in funding of respite services in Free Standing Respite Centers.

Effective October 1, 2003, respite delivered in Free-Standing Respite Centers is an HCBS Waiver service. For consumers enrolled in the HCBS Waiver who are served in Free-Standing Respite Centers, MSC service coordinators must make sure to include this respite service in consumers' ISPs and a copy of the updated ISP must be sent to the Free-Standing Respite provider. For those HCBS waiver enrolled consumers who do not receive MSC, their PCSS service coordinator must follow the same procedures for ensuring the ISP is updated and that a copy is sent to the Free-Standing Respite provider.

#### **ACTIONS REQUIRED OF THE MSC AND PCSS SERVICE COORDINATOR:**

Federal requirements call for the identification of all a consumer's HCBS Waiver services in the ISP. If a consumer receives an HCBS Waiver service that is not authorized by the ISP, the HCBS Waiver service provider's billing is put at risk. MSC service coordinators must ensure that ISPs they develop are updated throughout the year to reflect any new HCBS Waiver services and that the ISPs are distributed in accordance with the MSC Vendor Manual (Chapter 4, pp. 4-6). PCSS service coordinators must follow the same procedures, however it is the responsibility of the consumer to contact the PCSS service coordinator to initiate any changes to the ISP should they be needed prior to the next six month ISP review.

#### **ACTIONS TAKEN FOR NON-COMPLIANCE:**

##### Vendor Agency MSC Programs

The OMRDD Division of Quality Assurance (DQA) conducts two types of HCBS Waiver service reviews. DQA Program Certification routinely performs quality reviews and the DQA Bureau of Fiscal Audit conducts "Billing and Claiming Audits" for selected Medicaid/HCBS waiver services. In both reviews, DQA monitors ISPs to ensure that HCBS waiver services a consumer receives have been authorized by the ISP. DQA also monitors to ensure that the service coordinator has properly distributed copies of the ISP to HCBS waiver service providers in a timely manner. Repeated and systemic failure of an MSC vendor to comply with applicable regulations and the MSC Vendor Manual requirements could result in the cancellation of the vendor's contract.

##### DDSO MSC Programs

The OMRDD Bureau of Training and Medicaid Standards conducts internal compliance reviews of DDSO-delivered MSC. Included in the review is a comparison of services listed in the ISP with HCBS waiver service billings to ensure that all HCBS waiver services a consumer receives have been authorized in the ISP. The Bureau has also established a review in which HCBS waiver service providers are queried to ensure that the service coordinator has properly distributed copies of the ISP to the service

providers in a timely manner. Where the Bureau identifies deficiencies in the DDSO's management of ISP responsibilities, the DDSO will be required to submit a plan of corrective action for approval. The Bureau of Training and Medicaid Standards will monitor actions to implement the approved plan and will take further action if necessary.

**TECHNICAL ASSISTANCE CONTACT:**

If you have questions on this advisory, please contact Carol Kriss, Statewide MSC Coordinator at (518) 474-4904 or Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

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**ADMINISTRATIVE MEMORANDUM - #2005-01**

**To:** Executive Directors of Agencies Authorized to Operate Article 16 Clinics  
Executive Directors of Agencies Authorized to Operate Joint Clinic  
Operations  
Executive Directors of Agencies Authorized to Provide Medicaid Service  
Coordination (MSC)  
DDSO Directors

**From:** Gary Lind, Director   
Policy, Planning and Individualized Initiatives

**Subject:** Standards for Article 16 Clinics

**Date:** February 18, 2005

**Suggested Distribution:**

Clinic Administrators and Treatment Coordinators  
Clinic Staff  
Quality/Compliance Staff  
MSC Service Coordinators and Service Coordinator Supervisors

**Purpose**

This is to review requirements for Article 16 clinics (clinic treatment facilities) certified by the NYS Office of Mental Retardation and Developmental Disabilities (OMRDD). The requirements contained in this administrative memorandum provide additional detail to the components and definitions of clinic visits, identify documentation guidelines and essential standards of practice, and add specificity to applicable principles of compliance found in 14 NYCRR Part 679 and Article 16 of the Mental Hygiene Law. Together, these requirements are the basis for OMRDD program and fiscal reviews of all Article 16 clinic operations, including DDSO joint clinic operations with voluntary agency providers.

## Background

Title 18 NYCRR, Section 504.3(a) states that by enrolling in the Medicaid program, “the provider agrees...to prepare and to **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 of care, services or supplies were furnished, all records** necessary to disclose the nature and extent of services furnished and 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 clinic claims, including OMRDD.

The regulatory basis for requirements contained in this Administrative Memorandum is in 14 NYCRR Sections **679.1** (d) (2) & (4); **679.3** (b), (c) (6) & (8), (d), (g), (h), (m), (o), (q) & (t); **679.4** (h), (j) (3)-(6), (k) (2) & (m); **679.5** (c); **679.6** (i); and **679.99** (a), (f), (h) & (i).

## Clinic Visits

Article 16 clinics may receive reimbursement for clinic visits based on the number of minutes of face-to-face service/encounter that is provided to an individual.

- Face-to-face service/encounter time is defined as the duration of time during which the authorized party directly provides individualized attention, care, and treatment to an admitted person, potential admittee, collateral or other specified party and may include such tasks as obtaining a history, conducting an assessment/evaluation and performing an examination or treatment. Face-to-face service/encounter time also includes observation time directly associated with the individualized clinical intervention.
- Face-to-face service/encounter time does **NOT** include the time the person or party spends getting ready to begin, resting, toileting, waiting for equipment, or independently using equipment, or the authorized party’s pre and post delivery services/encounter time.
- Pre and post delivery services/encounter time is the time spent by the authorized party before and/or after a face-to-face service/encounter performing the following tasks:
  1. Reviewing records and tests.
  2. Arranging for additional services.
  3. Communicating with other professionals or service providers in any manner, such as in person, through written reports or telephone or electronic contact.
  4. Communicating with the person, the collateral, or others through written reports or telephone contact.
  5. Documenting the face-to-face service/encounter in the clinical record.

- If an authorized party begins to provide a face-to-face service/encounter to an individual and the individual refuses to stay, becomes disruptive or a piece of equipment fails, etc., thus preventing the completion of the service delivery, the **ACTUAL** time spent providing the face-to-face service/encounter can be claimed for reimbursement. These situations should be clearly documented in the clinical record to prevent claiming disallowances.
- The following types of clinic visits with the specified duration of face-to-face service/encounter are authorized for reimbursement:
  1. Intake visit - 30 minutes or more of face-to-face service/encounter time with a potential admittee, his/her collateral and/or the referral source. If the potential admittee cannot be present, there must be documented clinical justification for the absence of the potential admittee.
  2. Full clinic visit - 30 minutes or more of face-to-face service/encounter time within a single day for an appropriately admitted person by one or more licensed/certified professional(s), and/or those authorized to provide services under Part 679. If the full clinic visit consists of more than one face-to-face service/encounter, the minimum duration of each service/encounter must conform to the standards for a brief clinic visit (see below).
  3. Brief clinic visit - fewer than 30 minutes of face-to-face service/encounter time. The minimum duration of face-to-face service/encounter time for a brief visit must be 15 minutes, except for:
    - Medical services, including specialty medical services and dental services delivered by a physician, physician assistant, nurse practitioner or dentist, or students-in-training in those disciplines;
    - Immunizations and TB screenings; and
    - Other services, if there is a documented clinical justification for the delivery of services of a shorter duration.
  4. Group clinic visit - 45 minutes or more of face-to-face service/encounter time for individuals over 18 years old and 30 minutes or more of face-to-face service/encounter time for individuals under 18 years old. Group clinic visits can be provided for a maximum of 12 persons.
  5. Collateral clinic visit - 30 minutes or more of face-to-face service/encounter time with the collateral of an appropriately admitted person. Services delivered during a collateral clinic visit are limited to those services that contribute to meeting the identified needs of the admitted person with developmental disabilities. Collateral may only be:

- A member of the family, defined as biological/adoptive family, guardian, foster care parent, or family care provider; or
  - A non-related party, who has a long-term care-giving relationship with the admitted person with developmental disabilities, provided they are not being paid to provide clinical or direct care-giving services to that person.
6. Comprehensive diagnostic and evaluation visits - 2 hours or more of face-to-face service/encounter time. An interdisciplinary or discipline specific comprehensive visit may be reimbursed when the visit consists of a comprehensive assessment protocol sufficient in scope to completely describe and analyze the person's functional status, and if the cumulative face-to-face service/encounter time provided to a person and collateral (for purposes of completing an appropriately administered assessment protocol) on the same or different days is two hours or more. If the comprehensive diagnostic and evaluation visit is conducted over more than one day, the service date for billing purposes is the last day that the face-to-face service/encounter occurs.

### **Clinic Nursing Services**

Article 16 clinic nursing services shall consist of professional services that require the skill or direction of a registered nurse (RN) to perform. A licensed practical nurse (LPN) may provide nursing tasks within his/her scope of practice as defined by the NYS Education Department, under the direction of an RN, licensed physician, dentist, physician assistant and/or nurse practitioner directly employed by the Article 16 clinic.

- Any treatment generally considered first aid; collection of a laboratory specimen (including phlebotomy), or routine medication administration is **NOT** a reimbursable Article 16 nursing service.
- Medication administration is a reimbursable service only when medication is administered in connection with directly observed therapy for treatment of tuberculosis or for HIV/AIDS.
- Nursing services required by Administrative Memorandum #2003-01, Registered Nursing Supervision of Unlicensed Direct Care Staff in Residential Facilities Certified by the Office of Mental Retardation and Developmental Disabilities, are **NOT** reimbursable Article 16 nursing services.

### **Clinic Service Documentation**

Medicaid reimbursement rules require the inclusion of sufficient, supporting documentation in the person's clinical record to support the services delivered and claimed for reimbursement. Required service documentation elements are:

- The service date (month/date/year).
- The location of service delivery (e.g. Maple Avenue IRA).
- The duration of the face-to-face service/encounter (e.g. 35 minutes).
- A treatment note (progress note) describing the face-to-face service/encounter, i.e. what happened during the session; the tasks, activities and/or procedures performed that are associated with the person's clinic treatment plan, and the progress, result and/or the person's response to the clinic service.
- The full signature and title of the clinic staff providing the clinic service. (Full countersignature and title must be provided if required by the NYS Education Department).
- The date the note was written. (Medicaid rules require that the note must be contemporaneous to the service provision.)

### **Clinic Treatment Plans**

All clinic treatment plans shall be based on a current and written individualized, clinical examination, assessment and/or evaluation; be individually tailored, and shall contain the following elements:

- A description of the person's developmental disability, other documented diagnoses (medical and/or psychiatric), and the treatment diagnosis as well as symptoms, problems, complaints, or other need for the service(s). The treatment diagnosis must be related to the primary reason the service is provided.
- Identification of the therapy, therapies or specific type or modality of therapeutic intervention (e.g. physical therapy – gait training) that will be used to address the person's need(s), and the treatment goals.
- The frequency, type of clinic visit and location of service delivery. (Please note: If the service delivery is in an OMRDD-certified residence, the treatment plan must identify the specific clinic service and provide justification for the delivery of this service in the residence.).
- The clinic medical director (or designee) must review and approve all treatment plans at least annually, or when there are significant changes to the ongoing treatment plan, per §679.3 (q) & §679.4 (h).

### **Clinic Treatment Reviews**

Clinic treatment reviews shall be conducted that incorporate a review of the type and frequency of the specific clinic services. Such reviews shall also take into consideration the treatment goal(s) the plan is intended to achieve, whether treatment goals have been met, and/or whether

new goals need to be established. Clinic treatment goals should be established that incorporate expected achievements within specified time periods.

- The treating clinic practitioner or the clinic treatment coordinator, in consultation with the person receiving services and/or as appropriate, his/her collateral, must review clinic treatment outcomes and/or the course of clinic treatment at least semi-annually or as specified by the treating physician or dentist, or if there is significant change in the person's condition or service needs.
- The review of clinic treatment outcomes and/or the course of clinic treatment must be specific rather than general; quantifiable, if appropriate (i.e. percentage of goal achieved); and directly related to the person's clinic treatment plan.
- Documentation must indicate that the clinic treatment outcomes and/or the course of clinic treatment have been reviewed, and whether clinic treatment is to continue, be changed (next steps) or be discontinued.

#### **Annual Physician (Re)assessment**

The clinic medical director or designee (physician) shall assess all individuals annually as to the continuing need to be served by the clinic, per §679.3(t).

- The (re)assessment must include the review of the individual's treatment and evaluative and clinical/medical information.
- The review should take account of the type of clinic service provided, the frequency at which it is provided, the length of time it has been provided, the therapies or modalities employed in treatment, the intended treatment goals, and the clinical appropriateness of the treatment goals in relation to the individual's diagnosis(es), cognitive functioning, physical abilities and the provision of other clinical services to the person.
- Documentation must indicate the date of the (re)assessment and the physician's recommendations regarding continuing treatment and briefly, the rationale involved in the determination.
- The annual physician reassessment must be completed and dated no later than 31 days after a full calendar year has elapsed since the date of the last completed physician reassessment. For example: If the physician's reassessment is dated June 15, 2004, the date of the reassessment in 2005 must be on or before July 16, 2005.

## **Clinic Quality Assurance Plan**

The clinic quality assurance plan shall include a planned and systematic process for monitoring and assessing the quality and appropriateness of treatment, the clinical performance of staff, a means to resolve identified problems to improve treatment, and the opportunity to incorporate input of consumers, collateral, referral sources and other pertinent parties. The quality assurance process must:

- Specify written operational procedures and the staff responsible for quality assurance activities that include both program and individual service evaluation.
- Include individual service evaluation that is representative of the population being served by the clinic and the type of services being provided to that population.
- Define methods for the identification and selection of clinical and administrative problems to be reviewed.
- Establish review criteria in accordance with current standards of professional community practice.
- Document findings, trends, recommendations, and actions taken to resolve problem areas.
- Demonstrate timely implementation of necessary corrective actions.
- Provide for periodic assessment or re-assessment of the corrective actions taken.

## **Coordination of Clinic Treatment Plans**

The clinic treatment coordinator has primary coordination responsibility for all services, therapies and/or treatment provided to a person by the Article 16 clinic treatment program. The clinic treatment coordinator shall forward written treatment plan recommendations to the person's Medicaid Service Coordinator or other coordinator outside of the clinic program, and as appropriate, to other caregivers and referral sources. Written recommendations must be forwarded when the treatment plan is first developed; at least semi-annually when the review of clinic treatment outcomes and/or the course of treatment are completed; and whenever the clinic treatment plan is significantly changed.

- To avoid the duplication of clinical services, treatment plans must reflect and attempt to incorporate all of the person's other individualized written plans of services required by law or regulation. All plans should be generally consistent (i.e. not in conflict) and not duplicate the same clinical service or modality (e.g. gait training) from multiple sources. Plans can include: the Individualized Services Plan (ISP), the Individualized Education

Program (IEP), the Individual Program Plan (IPP), and clinic treatment plans for services delivered by other clinics.

1. If the person is enrolled in the OMRDD HCBS waiver, the clinic treatment coordinator should request that the Medicaid Service Coordinator provide a copy of the person's current ISP, so that this information can be considered when a clinic treatment plan is developed and can be included in the person's clinical record.
  2. If the person is a resident of an Intermediate Care Facility (ICF), the clinic treatment coordinator should request that the ICF administrator provide a copy of the person's IPP, so that this information can be considered when a clinic treatment plan is developed and can be included in the person's clinical record.
  3. If an OMRDD provider operates both a clinic certified pursuant to Article 16 of Mental Hygiene Law, and a clinic certified pursuant to Article 28 of Public Health Law, the clinic treatment plans for any person who is being served by both clinics must be coordinated.
- Treatment plans should be coordinated with clinical services delivered by other providers, including other clinics.
    1. If different clinic services are being provided to a person by two or more Article 16 clinics (e.g. clinic "A" is providing psychology services to the person while clinic "B" is providing occupational therapy to the same person), the clinical record and the clinic treatment plan for each clinic must include documentation that clearly indicates what service is being provided by each Article 16 clinic.
    2. If a particular clinic service (e.g. psychology) is being provided to a person by one Article 16 clinic, that service must not also be provided to the same person by another Article 16 clinic, unless there is a compelling clinical justification to do so (e.g. the person needs a specific treatment service that is only offered by a therapist from another clinic). The clinical record and the clinic treatment plan for each clinic must include documentation that the service is being provided by another Article 16 clinic, and include the clinical justification for the provision of the same service by two different clinics.
    3. If a person residing in an ICF receives Article 16 clinic services (because the specific clinical service is not included in the reimbursement rate for the ICF), the clinic treatment coordinator should provide a copy of the person's clinic treatment plan to the ICF administrator when the clinic treatment plan is first developed; at least semi-annually when the review of clinic treatment outcomes and/or the course of clinic treatment are completed; and whenever the clinic treatment plan is significantly changed.

## **Contract Clinician Organizations**

Clinical services provided by contract clinicians or contract clinician organizations for an Article 16 clinic shall be subject to control and oversight by the agency holding the Article 16 operating certificate. All referrals and recommendations for Article 16 clinic services must be reviewed and approved by the clinic medical director or other designated physician/dentist. Oversight of contract clinicians or contract clinician organizations shall be documented by the agency that holds the operating certificate for the Article 16 clinic.

- Contract clinicians or contract clinician organizations should not be the only mechanism used by an Article 16 clinic to obtain the services of clinicians. OMRDD expects that persons employed directly by the agency that holds the operating certificate for the Article 16 clinic will deliver a significant proportion of the clinical services.
- The agency which holds the operating certificate must describe in its clinic program policy and procedure manual or similar document, the plan to provide oversight of services delivered by contract clinicians or contract clinician organizations. The plan must specify how staff directly employed by the agency which holds the operating certificate will oversee the development of all clinic treatment plans and updates to the treatment plans.
- The agency which holds the operating certificate must document the oversight of contract clinicians or contract clinician organizations through monitoring reports that detail the type, frequency and location of clinical services provided, the review of “sign-in” and “sign-out” logs for clinicians, and visits to actual service delivery locations. Staff directly employed by the agency that holds the operating certificate must conduct the monitoring reports and reviews.
- The agency which holds the operating certificate must retain the final authority to decide what services will be delivered to each person, and the amount, frequency and length of time the services will be provided, and may not delegate final decision-making responsibility for such decisions.
- The agency which holds the operating certificate must retain the authority to adopt and enforce policies governing services delivered by the clinic, or by any party or organization hired or under contract to provide services.
- The agency which holds the operating certificate must retain access to and right of control of all books, records and supporting documents in connection with the operation of the clinic, and may not transfer ownership of, or relinquish control of such books, records and supporting documents except as otherwise required by law.

- The agency which holds the operating certificate must retain the authority to incur debts or liabilities and enter into contracts, and may not allow another party or organization to incur debts or liabilities or enter into contracts on their behalf.
- The agency which holds the operating certificate must not allow any part of an organization that is providing services on their behalf as an independent contractor, to do any marketing or advertising for or on behalf of the clinic program.

### **Clinic Administration**

- The clinic administrator of an Article 16 clinic must be directly employed by the agency that holds the Article 16 clinic operating certificate.
- The clinic administrator, the medical director, and/or the medical director designee of an Article 16 must not have interests that could materially affect his/her objective judgment when making decisions about the provision of Article 16 clinic services.

### **Effective Date**

June 1, 2005

### **Contact Information**

For additional information, please contact Larry Zawisza at 518-473-9697 or e-mail [larry.zawisza@omr.state.nv.us](mailto:larry.zawisza@omr.state.nv.us).

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**ADMINISTRATIVE MEMORANDUM - #2005-02**

**TO: Executive Directors of Agencies Authorized to Provide  
Respite Services**

**Executive Directors of Agencies Authorized to Provide  
Medicaid Service Coordination**

**DDSO Directors**

**FROM: Jan Abelseth, Deputy Commissioner,  
Quality Assurance**

**Gary Lind, Director,  
Planning and Individualized Initiatives**

**James F. Moran, Deputy Commissioner,  
Administration and Revenue Support**

**SUBJECT: HCBS RESPITE/NON WAIVER ENROLLED  
(NWE) RESPITE SERVICE DOCUMENTATION REQUIREMENTS**

**DATE: June 15, 2005**

**Suggested Distribution**

Respite Program/Service Staff  
Quality Compliance Staff  
Billing Department Staff  
MSC Service Coordinators and Service Coordinator Supervisors

**Purpose**

This is to specify Respite service documentation requirements that support a provider's claim for reimbursement. These service documentation requirements apply to Home and Community Based Services (HCBS) Waiver Respite and "non-Waiver enrolled" (NWE) Respite Services provided in all settings. NWE Respite, also known as "mirrored" HCBS Respite, is provided to consumers not enrolled in the HCBS waiver.

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In addition to the claim documentation requirements specified in this Administrative Memorandum (ADM), Respite providers 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).

### **Background**

18 NYCRR, Section 504.3 (a) states that by enrolling in the Medicaid program, "the provider agrees... to prepare and to **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" (emphasis added). It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for HCBS Respite is found in 14 NYCRR sections 635-10.4 (g) and 635-10.5 (h).

### **Billing Respite Services**

Claims for payment of Respite services provided in Free-Standing Respite Centers and all other locations are submitted to E medNY and OMRDD in 15-minute billing units. Respite service staff document the start and end time of a consumer's Respite services on a given day. The Respite provider's billing department uses the start and end time to determine the number of 15-minute billing units to be claimed. For example, where Respite service is provided to a consumer from 3:00 p.m. to 4:30 p.m., the billing department claims six 15-minute billing units. **Respite services require in-person or "face-to-face" service provision by Respite staff.**

Respite services are not always provided for a continuous time period on a given day. For example, a consumer may receive Respite service at a Free-Standing Respite Center from 9:00 a.m. to 10:00 a.m., and then leave to attend a Day Habilitation program. After the Day Habilitation service, the consumer may again receive Respite services at the center from 3:00 p.m. to 5:00 p.m. in the afternoon. In this case, the total billable duration for Respite services for the day is twelve 15-minute billing units (four billing units in the morning plus eight in the afternoon).

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**Service Documentation**

Service documentation must be contemporaneous with Respite service provision. **Required service documentation elements are:**

1. Consumer's name, TABS ID and if applicable, the Medicaid ID (CIN)
2. Identification of the category of waiver service provided, which, in this case, is "Respite"
3. Name of the agency providing the Respite service (that is, your agency)
4. The date the service was provided
5. The start time and stop time for each continuous period of Respite service
6. Verification of service provision by the Respite staff person who delivered the service (this is accomplished with a staff signature and title)
7. The date the service was documented (that is, the date must be "contemporaneous" with service provision).

The "**Respite Documentation Record – Individual Summary**" attached to this Administrative Memorandum incorporates all the "**required service documentation elements**" specified above. Respite providers must use the attached record or one that incorporates all the above specified service documentation elements to document the Respite services provided to each consumer. A contemporaneous entry must be made on the Respite Documentation Record for each day a Respite service is delivered and billed for a consumer.

**Special Billing Rules**

Consumer travel time to receive Respite at the start of the Respite service **does not** count as billable time nor does travel home from a Respite program

Where Respite services are provided at various community sites, the time a consumer spends traveling with Respite staff to these sites may be counted as billable Respite time.

Time the consumer spends at his/her day program(s), **does not** count as billable Respite time.

**Billable respite service time requires in-person or "face-to-face" service provision by Respite staff.**

### **Other Documentation Requirements**

In addition to the "Respite Documentation Record," the Respite provider must have a copy of the consumer's current Individualized Service Plan (ISP) on file.

For consumers enrolled in the HCBS waiver, the ISP, which is developed by the consumer's Medicaid Service Coordination (MSC) service coordinator or Plan of Care Support Services (PCSS) service coordinator, serves as the "authorization" for the Respite service. The ISP must include the following elements related to the Respite service:

1. Respite must be included as a waiver service the consumer receives and your agency must be identified as the provider of the Respite service.
2. For Frequency and Duration of the Respite service, specify that the Frequency is "an hour" since, for HCBS waiver purposes, the unit of service for Respite is an hour. In all cases, specify the Duration as "ongoing".
3. The Effective Date for Respite services. This date must be on or before the first day of service that your agency bills for Respite services.

**Since Respite is not a habilitation service under the HCBS waiver, a Habilitation Plan is not required.**

### **Documentation Retention**

All documentation specified above, including the ISP and Respite service documentation, must be retained for a period of at least six years from the date of the Respite 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.

For additional information on the documentation requirements or to request an example of a completed "Respite Documentation Record," contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408-2096, or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

cc: Provider Associations  
FSS Coordinators  
HCBS Waiver Coordinators  
Helene DeSanto  
Kathy Broderick  
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Lori Lehmkuhl  
Carol Metevia  
Kevin O'Dell  
David Picker  
Wake Gardner  
Linda Reinhardt



**Instructions for Completing  
Respite Documentation Record - Individual Summary**

Items 1-14 to be completed by Respite Service Staff

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**Agency and Consumer Identifying Information**

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1. **Respite Service** = Indicate whether services recorded are “Hourly Respite” or “Free Standing Respite”. “Free Standing Respite” is a program which provides respite services outside the individual’s home. The program is “free standing” since it is operated in its own space which is separate and distinct from any certified facility. “Hourly Respite” is respite provided in all other settings, including a consumer’s home.
2. **Agency Name** = Enter the name of your Agency, that is, the agency providing the Respite service.
3. **Consumer Name** = Enter the name of the consumer receiving the Respite service.
4. **Medicaid ID Number** = For a consumer enrolled in the HCBS Waiver, enter the Medicaid Client Identification Number (the “CIN”).
5. **TABS ID** = For all consumers, enter the consumer’s TABS ID number.
6. **Program Location** = Enter the address where the Respite service is provided.
7. **TABS Program Code** = Enter the code assigned to your Respite service in OMRDD’s TABS system.
8. **Is Consumer HCBS Waiver Enrolled?** = Check **Yes** if the consumer is enrolled in the HCBS Waiver. Check **No** if the consumer is not enrolled in the HCBS Waiver. For a consumer enrolled in the HCBS Waiver, your agency will bill eMedNY (i.e. the Medicaid billing system) for Respite services. For a consumer not enrolled in the HCBS Waiver, your agency will report services using the internet web-based application.

**Exception: Respite provided to any consumer enrolled in Family Care cannot be billed to Medicaid. Please contact your DDSO Family Care Coordinator for instructions on how to arrange for payment.**

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**Documenting Respite Service Delivery**

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9. **Service Delivery Date** = Enter the date on which Respite services are provided. When the Respite stay continues over several days, services delivered on different days must be entered on separate lines. For example, if a consumer arrives at the respite program at 4:00 p.m. on March 2, 2006 and leaves on March 3, 2006, the March 2 and March 3 Service Delivery Dates are entered on separate lines.
10. **Start time** = Enter the time Respite services start.
11. **End Time** = Enter the time Respite services end.

For overnight Respite stays, the end time for the "Service Delivery Date" is always midnight. The hours after midnight are shown on the next service delivery date. For example: if a consumer arrives for an overnight Respite stay on 12/7/06 at 4:00 p.m. and leaves the next morning on 12/8/06 at 10:00 a.m., the "Start Time" for the 12/7/06 service delivery date is 4:00 p.m. and the "End Time" is 12:00 midnight. The "Start Time" for the 12/8/06 service delivery date is 12:00 midnight and the "End Time" is 10:00 a.m.

When a consumer has breaks in Respite service on a given day, each continuous period of service delivery (or session) is entered on a separate line on the Respite Documentation Record- Individual Summary document. For example, on 1/3/06, a consumer receives Respite services for a one hour session in the morning (from 9:00 a.m. to 10:00 a.m.), and then leaves to attend a Day Habilitation program. After the Day Habilitation service, the consumer again receives Respite services for a two hour session in the afternoon (from 3:00 p.m. to 5:00 p.m.). Two lines on the Respite Documentation Record-Individual Summary must be completed to document the Respite services delivered on 1/3/06. On one line, Respite staff document a "Start Time" of 9:00 a.m. and a "Stop Time" of 10:00 a.m. for the 1/3/06 "Service Delivery Date." On the next line on the Individual Summary Sheet, Respite staff again enter 1/3/06 under the "Service Delivery Date" column and document the afternoon session by entering the "Start Time" as 3:00 p.m. and the "Stop Time" as 5:00 p.m.

12. **Staff Signature** = A Respite staff person must sign on each "Service Delivery Date" line. **By signing the staff person is verifying that Respite was provided for the hours shown.**
13. **Staff Title** = The staff person must enter their work title.
14. **Date of Signature** = The staff person must enter the date (in month, day, year format) he/she signed.

**Items 15 and 16 to be completed by the Respite Provider's Billing Department**

15. **Service Delivery Time** = Based on the "Start Time and End Time" of service delivery on each line of the Respite Documentation Record-Individual Summary, enter the duration of Respite services the consumer received. For example, if on 1/7/06 the consumer arrived at 6:00 p.m. and left at 10:00 p.m., enter four hours for the Service Delivery Time.
16. **Billing Units** = The billing unit for this service is 15 minutes. For each line of the Respite Documentation Record-Individual Summary convert the "Service Delivery Time" into the appropriate number of 15 minute billing units and enter the number in this column.

**Examples: "Service Delivery Time," and "Billing Units"**

If on 9/1/06 a consumer's "Service Delivery Time" is 5 hours and 15 minutes, enter 21 billing units.

**NOTE TO BILLING STAFF**

All billing units provided on a single date of service are to be added together for billing purposes. Rounding up" is not allowed. For example, if the consumer receives Respite service for ten hours and ten minutes, only 40 15-minute billing units are entered and billed.

**Special Rules for Calculating Billing Units**

- **Consumer travel time to and from a Respite program is excluded.** Staff should be instructed to use the consumer's time of arrival at the program as the "Start Time" of the service. The "End Time" of the service is the time the consumer leaves the program.
- **Consumer travel time can be billed when a Respite staff member accompanies the consumer into the community as part of the Respite program.** For example: The consumer arrives at the Respite program at 10:00 a.m. on 12/5/2006. At 11:00 a.m., respite staff takes the consumer to a holiday show, returning at 1:00 p.m. The consumer leaves the respite program at 4:00 p.m. Since the travel time to and from the holiday show occurred as part of the Respite program and involved respite staff service provision, it is billable time. The Respite agency documents that service was delivered from 10:00 a.m. to 4:00 p.m. on 12/5/2006 and 24 15-minute billing units are billed.
- **Time the consumer spends at his/her day program or any other activity that is not part of the Respite service is excluded.** Staff should be instructed to record start and end times accordingly.

**For additional information regarding the completion of the Respite Documentation Record - Individual Summary, please contact Mr. Earl Jefferson, Training and Medicaid Standards Bureau, OMRDD at (518) 408-2096.**

**For assistance with MMIS billing, please contact Mr. Wake Gardner, Central Operations, OMRDD at (518) 402-4333. For assistance with billing "non-waiver" Respite through the internet web-based application, please contact Ms. Linda Reinhardt, Central Operations, OMRDD at (518) 402-4333.**



George E. Pataki  
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Thomas A. Maul  
Commissioner

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**MEMORANDUM**

**TO:** Executive Directors of Agencies Providing Medicaid Service Coordination  
Executive Directors of Agencies Providing Waiver Habilitation Services  
Executive Directors of Agencies Providing Article 16 Clinic Services  
DDSO Directors

**FROM:** Gary Lind, Director  
Policy, Planning, and Individualized Initiatives

**DATE:** January 14, 2005

**SUBJECT:** OMRDD Advisory on Changes to the Individualized Service Plan (ISP) Format

**Distribution:**

Medicaid Service Coordination Supervisors  
MSC Service Coordinators  
Clinic Administrators and Clinic Treatment Coordinators  
Agency Quality Assurance or Compliance Staff

**Purpose:**

The purpose of this advisory is to inform service coordinators and their supervisors of changes to the required format of the Individualized Service Plan (ISP). Based on the October 1, 2004 federal approval of the HCBS Waiver, a new format for the ISP has been developed and will become effective on April 1, 2005. The new ISP basic format must be followed. A copy of the newly revised format is attached to this memo along with detailed instructions that describe how to complete each section of the ISP.

Please ensure that this memo and attachments are distributed to all agency staff who will use the new ISP format, specifically MSC Service Coordinators and MSC Supervisors. A series of training sessions will be conducted through live regional presentations and videoconferences in January and February 2005. Your staff can receive information and register online at: [www.omr.state.ny.us](http://www.omr.state.ny.us).

As stated, these changes are effective April 1, 2005. MSC Service Coordinators may begin to use the new format before that date. All ISPs do not have to be written in the new required format by April 1, 2005. However, as ISP reviews are completed after April 1, 2005, ISPs must be written in the new format.

The ISP format changes in this memorandum supercede the requirements in The Key to Individualized Services – The Home and Community Based Services Waiver Provider Guide (OMRDD, 1997) and The MSC Vendor Manual (OMRDD, September 2002). The quality standards in The Key and The MSC Vendor Manual remain the same.

### **Description of Significant Changes to the ISP Format:**

There are three significant changes to the ISP Format:

1. The header of the ISP has changed to add documentation regarding the **date that the ISP was reviewed and the MSC Service Coordinator's initials** (see page 1 of the Individualized Service Plan attached). Each date that the ISP was reviewed must be documented here. The ISP must be reviewed at least every 6 months, first from the month of the initial plan and then from the month of the last review date. If an addendum is written, the MSC Service Coordinator must date and initial this section of the header to indicate that an addendum is attached.
2. Medicaid State Plan Services have been separated into two distinct sections on two separate pages (see pages 4 and 5 of the Individualized Service Plan attached).

**Medicaid State Plan Services** (on Page 4) continue to list those services that a person can access with his or her Medicaid card. These services include Medicaid Service Coordination, physician, pharmacy, laboratory, hospital, clinic, dental, physical therapy, audiological, durable medical equipment, day treatment, and psychology. Medical, nursing, and dental state plan services provided in an Article 16, 28 or 31 clinic should be described in this section.

**Medicaid State Plan Services – Article 16, 28, or 31 Clinics Long-Term Therapies Only** (e.g., Physical, Occupational, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work, and Psychiatry), are services that are provided through clinics. This new section requires that the MSC Service Coordinator indicate which type of Clinic (e.g., 16, 28, or 31), is providing the service. Also include at what location the service is being provided, (e.g., main clinic site, day or residential program).

3. At the end of the ISP (page 8 of the attached ISP basic format), there is a place for the MSC Service Coordinator to document the **names of the service providers receiving copy(s) of ISP and attachments**. The MSC Service Coordinator should list the service providers that have received a copy of the ISP and the date that it was sent. It is important that the Medicaid Service Coordinator distribute the ISP and attached habilitation plans in a timely manner to the appropriate service providers. It is also important for the habilitation provider to submit habilitation plans to the MSC in a timely manner. The habilitation service providers must have a copy of the ISP and attached habilitation plans in order to ensure continuity of service quality and to justify Medicaid billing for habilitation services.

Additionally, please note the following two new waiver services listed on page 7 under **Types of HCB Waiver Services**:

1. **Fiscal/Employer Agent Services** provides the support and services to assist Consolidated Supports and Services (CSS) participants manage their service funds. The service involves an OMRDD approved not-for-profit agency performing billing, payment, reporting and selected employment-related services provided only for CSS participants as authorized in their approved CSS plan/budget.

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2. **Transitional Services** are supports that assist waiver participants who are moving from an institutional residence (e.g., Intermediate Care Facility [ICF], developmental center, nursing facility, or residential school) to their own home or a Family Care home. The service funds initial start up costs such as essential furnishings, moving expenses, and security deposits.

If you have questions regarding this memo, please contact Maryhelen Lounello in the Bureau of Waiver Management at (518) 474-5647.

cc: Thomas Maul, Commissioner  
OMRDD Senior Staff  
Provider Association  
DDSO MSC Coordinators  
Kevin O'Dell  
Allen A. Schwartz, Ph. D.  
Maryhelen Lounello  
Carol Kriss  
Carol Metevia









## Individualized Service Plan

Name of the Person: \_\_\_\_\_ ISP Effective Date: \_\_\_\_\_

### Medicaid State Plan Services:

For each service briefly state the name of the provider or agency (e.g., Dr. Smith, ARC Day Treatment Center, Southern DDSO Clinic); the type of service (e.g., physician, day treatment, MSC, transportation, durable medical equipment, etc.); the frequency of the service (e.g., daily, 5 days a week, yearly); the duration (e.g., on-going) and effective date (e.g., 3/97, 5/14/99, or approximate time frame: within the past year, etc.) and the person's valued outcome (from Section 1 of the ISP) or reason for receiving the support or service.

Examples of Medicaid State Plan Services: Medicaid Service Coordination, Day Treatment, Physician, Pharmacy, Laboratory, Hospital, Dental, Audiological, Personal Care, Certified Home Health Care, Durable Medical Equipment, Transportation, other.

**Note: Long term therapies provided in Article 16, 28, or 31 Clinic should not be included below. (See section "Medicaid State Plan Services: Article 16, 28, or 31 Clinic Long-term Therapies Only"). However, medical or dental state plan service provided in an Article 16, 28, or 31 Clinic should be described below.**

Name of Provider: \_\_\_\_\_  
Type of Medicaid Service: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Provider: \_\_\_\_\_  
Type of Medicaid Service: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Provider: \_\_\_\_\_  
Type of Medicaid Service: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Provider: \_\_\_\_\_  
Type of Medicaid Service: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Individualized Service Plan

Name of the Person: \_\_\_\_\_ ISP Effective Date: \_\_\_\_\_

**Medicaid State Plan Services – Article 16, 28, and 31 Clinics Long-Term Therapies Only (Physical Therapy, Occupational Therapy, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work and Psychiatry):**

For each service briefly state the name of the provider or agency (e.g., Metropolitan Article 28 Clinic, Western Article 16 Clinic); check the box to indicate the Clinic Certification Category (e.g., Article 16); the type of clinic service (e.g., physical therapy, speech pathology); the frequency of the service (e.g., 3 days a week); the duration (e.g., on-going) and effective date (e.g., 3/97, 5/14/99; or approximate time frame: e.g., within the past year); the person's valued outcome (from Section 1 of the ISP) or reason for receiving the support or service; and location the service will be provided (e.g., main clinic site, day program, or residential program).

Name of Provider: \_\_\_\_\_

Article 16  Article 28  Article 31

Type of Clinic Service: \_\_\_\_\_

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_

At what location will the service be provided (e.g., main clinic site or at the day or residential program)?

Name of Provider: \_\_\_\_\_

Article 16  Article 28  Article 31

Type of Clinic Service: \_\_\_\_\_

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Person's Valued Outcome or Reason for Receiving the Service: \_\_\_\_\_

At what location will the service be provided (e.g., main clinic site or at the day or residential program)?



## Individualized Service Plan

Name of the Person: \_\_\_\_\_ ISP Effective Date: \_\_\_\_\_

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**HCB Waiver Service Summary:** Complete a section below for each waiver service. Add more pages as needed.

For each service briefly state the **name** of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO); the **type** of service (e.g., residential habilitation, supported employment, environmental modification); the **frequency** of the service (billing unit of service); the **duration** (e.g., on-going) and **effective date** (e.g., 1/1/99) and the **person's valued outcome** (from Section 1 of the ISP) or **reason** for receiving the support or service.

<b>Name of Provider:</b> _____
<b>Type of Waiver Service:</b> _____
<b>Frequency:</b> _____ <b>Duration:</b> _____ <b>Effective Date:</b> _____
<b>Person's Valued Outcome or Reason for Receiving the Service:</b>
_____
_____

<b>Name of Provider:</b> _____
<b>Type of Waiver Service:</b> _____
<b>Frequency:</b> _____ <b>Duration:</b> _____ <b>Effective Date:</b> _____
<b>Person's Valued Outcome or Reason for Receiving the Service:</b>
_____
_____

<b>Name of Provider:</b> _____
<b>Type of Waiver Service:</b> _____
<b>Frequency:</b> _____ <b>Duration:</b> _____ <b>Effective Date:</b> _____
<b>Person's Valued Outcome or Reason for Receiving the Service:</b>
_____
_____

**Types of HCB Waiver Services:**

- |                          |                                    |                  |
|--------------------------|------------------------------------|------------------|
| residential habilitation | prevocational services             | day habilitation |
| supported employment     | environmental modifications        | respite          |
| adaptive devices         | plan of care support services      |                  |
| fiscal/employer agent    | consolidated supports and services |                  |
| transitional services    | family education and training      |                  |



# ISP Instructions

## I. SECTION BY SECTION INSTRUCTIONS

### **The Header**

#### **Name of the person:**

Name of the person for whom the ISP is written.

#### **ISP Effective Date:**

Date the service coordinator wrote the ISP. This date does not change until a new ISP is written.

#### **Medicaid Number or CIN Number:**

The person's Medicaid number, also known as the person's Client Identification Number.

#### **ISP Review Dates:**

List each date the ISP was reviewed. The ISP is reviewed at least every 6 months, first from the month of the initial plan and then from the month of the last review date.

### **Section 1:**

#### **The Profile, the Person's Valued Outcomes, and Safeguards**

##### **Profile:**

**The Profile** is a narrative about the person. It includes selected person centered information about the person discovered during the planning process. The profile may address abilities, skills, preferences, accomplishments, relationships, health, cultural traditions, community service and valued roles, spirituality, career, recreational interests and enjoyment, challenges, needs, pertinent clinical information, or other information that impacts how supports and services will be provided.

The profile tells the reader about the person and his/her current needs and wants. It assists those helping the person provide supports and services with an understanding and sensitivity to what is important to the person. This information is necessary to successfully put the plan into action.

### **The Person's Valued Outcomes:**

List the person's valued outcomes that derive from the profile. They are the person's chosen life destinations. There must be at least one valued outcome for each waiver habilitation service (residential habilitation, day habilitation, prevocational services, and supported employment) that the person will be receiving. The Habilitation Service is "authorized" only where the service relates to at least one of a person's valued outcomes. List the outcome again for each appropriate waiver habilitation service in the "HCB Waiver Service Summary."

### **Safeguards:**

State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. The Habilitation Plans, or referenced documents, will provide greater detail about how safeguards are ensured within the context of the respective service. The "Individual Plan for Protective Oversight" can be referenced in the safeguards section for people who live in an IRA. Fire safety must be discussed in the safeguard section of all ISPs unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs.

### **Section 2:**

#### **The Person's Individualized Service Environment**

Section 2 of the ISP lists all the supports and services received to help the person live a successful life in the community and pursue his or her valued outcomes. Supports and services are coordinated to keep the person healthy and safe from harm.

#### **Natural Supports and Community Resources:**

Natural Supports and Community Resources exist in the community for everyone. They are routine and familiar supports that help the person be a valued member of his or her community and live successfully on a day-to-day basis at home, at work, at school, or in other community locations.

List people, places, or organizational affiliations that are a resource to the person by providing supports or services, such as family, friends, neighbors, associations, community centers, spiritual groups, school groups, volunteer services, self-help groups, clubs, etc. Include the name of the person, place or organization and a brief statement about what is being done to help the person.

Assistance related to achieving a valued outcome should be noted. It is not required to include the frequency, duration, and effective date for the support or service as you would for the funded services.

Example entry: “John’s neighbor, Harry Smith, helps John with his grocery shopping every Saturday”; or “John is a member of the local fire department and attends most of the scheduled activities, especially the Tuesday night meetings.”

**Funded Services:**

**Medicaid State Plan Services** are those services that a person can access with his or her Medicaid card. These services include **Medicaid Service Coordination**, physician, pharmacy, laboratory, hospital, dental, physical therapy, audiological, durable medical equipment, day treatment, and psychology.

Medical, nursing, or dental state plan service provided in an Article 16, 28, or 31 Clinic should be described in this section.

**Medicaid State Plan Services – Article 16, 28, and 31 Clinics Long-Term Therapies Only, (e.g., Physical, Occupational, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work, and Psychiatry)**, are services that are provided through clinics. In this section, the Service Coordinator must indicate which type of Clinic (e.g., 16, 28, or 31), is providing the service. Also include at what location the service is being provided, (e.g., main clinic site, day or residential program).

**Federal, State, or County Services** are government services funded by agencies other than OMRDD. These include Vocational and Educational Services for Individuals with Disabilities (VESID), State Office for the Aging (SOFA), Housing and Urban Development (HUD), Board of Cooperative Educational Services (BOCES), Department of Health (DOH), Department of Social Services (DSS), public schools, etc.

**HCBS Waiver Services** are those services funded by the Home and Community-Based Waiver. These are residential habilitation, day habilitation, prevocational services, supported employment, respite, adaptive devices, environmental modifications, family education and training, plan of care support services, consolidated supports and services, fiscal/employer agent, and transitional services.

**Other Services or 100% OMRDD Funded Supports and Services** are services that do not fit in the other categories or are solely funded by OMRDD and have no Medicaid funding. These are Family Support Services, Individualized Support Services, and some Community Service Plan services such as Non-Waiver Enrolled service coordination.

**Required Information for Medicaid State Plan Services; Federal, State and County Funded Resources; HCB Waiver Services; and Other or 100% OMRDD Funded Services:**

- **Name of the provider or agency** (e.g., Dr. Smith, Community General Hospital, VESID, Housing and Urban Development, Sunshine County ARC, or DDSO).
- **Type of provider or type of service** (e.g., physician, cardiologist, educational, residential habilitation, housing, day treatment, or MSC).
- **Frequency of the support or service.** (e.g., daily; 3 days a week, monthly, twice a year, as needed, or one time purchase.) **The frequency of an HCB Waiver Habilitation Service must correspond to the billing unit of service.**
- **Duration of the support or service.** This means for how long the assistance is expected to last. If the service does not have an expected end date, write “on-going.”
- **Effective date of the support or service.** This is the date the current provider first provided the service. Effective dates may be difficult to obtain for some Medicaid State Plan Services; Federal, State and County Funded Resources; or 100% OMRDD Funded Services. In this situation, enter the approximate time frame (last few years, over 10 years, within the past year, etc.) However, HCB Waiver Services and Medicaid Service Coordination must have the exact and correct effective date. A HCB Waiver Service provider's billing will be jeopardized if the date the provider billed for the service is prior to the effective date on the ISP.

For a one time service or purchase, such as environmental modifications and adaptive devices, the anticipated purchase/completion date is used.

- **The reason or valued outcome** for receiving the support or service. e.g., to monitor seizure activity, to help obtain an apartment, to learn how to get from home to work.

If a service or support is helping the person to achieve a valued outcome (person's chosen life destination) as identified in the profile, then the outcome is required information for this entry.

If a service or support is not directly helping the person to achieve a valued outcome as identified in the profile, then a “reason” for why the person is buying a particular support or service is required information for this entry.

**Note: The above information (name and type of provider, frequency, duration, and effective date) must be accurate for HCB waiver services since the ISP substantiates the payment of these services.**

- List in each entry any clinical services received by the person within a service. For example, a person may receive psychology, physical therapy, or nursing as part of day treatment, residential habilitation, day habilitation, or an Article 16 Clinic. Coordination of Medicaid funded clinical services is critical and must not be unnecessarily duplicated. Ensure that Article 16, 28, and 31 Clinical services are coordinated with and do not duplicate other identical clinical services. For example, ensure that psychological services from an Article 16 Clinic do not duplicate identical psychological services within HCBS Waiver residential habilitation.

**Names of Service Providers receiving copy(s) of the ISP and attachments:**

The MSC should list who has received a copy of the ISP and when it was sent.

**Signatures:**

- the person,
- advocate (if the person is not self-advocating),
- service coordinator, and
- service coordinator’s supervisor.

Signature lines must not be blank. If the person is unable or unwilling to sign, this should be noted on the signature line. If the person is a self-advocate and the advocate is not signing, “self-advocate” should be written on the line. Signatures must be dated.

**Attachments:**

- waiver residential habilitation plan
- waiver day habilitation plan
- waiver prevocational services plan
- waiver supported employment plan
- waiver consolidated supports and services (CSS) plan
- individual plan for protective oversight if the person lives in an IRA
- Medicaid Service Coordination Activity Plan
- Clinic treatment plan (or written recommendations from Article 16, 28 or 31 clinics)

**II. FORMAT AND TIME FRAMES**

The first ISP is written within 60 days of the HCBS Waiver enrollment date (which can be found on the HCBS Waiver Notice of Decision form) or within 60 days of the MSC enrollment date, whichever comes first.

## **Updating the ISP**

The service coordinator ensures that the ISP is kept current (up-to-date), adapted to the changing outcomes and priorities of the person, as growth, temporary setbacks, and accomplishments occur.

If the ISP is not re-written and dated, changes may be made by attaching an **addendum**. The addendum must include the name of the person, the date of the ISP to which it is attached, the date of the change, the new or changed information, and the signature of the service coordinator.

The addendum requires new signatures if there are changes to HCB Waiver Services or the change is considered “significant” by the person, advocate, and service coordinator.

Changes in the ISP must be communicated to day treatment providers and HCB Waiver Habilitation service providers (residential habilitation, day habilitation, prevocational services and supported employment). If an addendum is used, distribute copies.

## **Reviews of the ISP**

The ISP is reviewed at least every 6 months, first from the month of the initial plan and then from the month of the last review date. ISP reviews must be held by the end of the 6<sup>th</sup> month.

The service coordinator is responsible for coordinating a review of the ISP and making any needed changes to the plan as the result of the review.

At least annually, the ISP review must be a face-to-face meeting with the service coordinator, consumer, advocate and major service providers (residential habilitation, day habilitation, prevocational, supported employment, or day treatment). Each major provider invited must send a representative.

## **Maintenance, Retention, and Distribution of the ISP:**

The signed ISP (with attachments) is maintained by the person’s service coordinator and filed in the service coordination record.

Copies of the signed ISP (with attachments) are forwarded by the service coordinator to:

- the person,
- his/her advocate,
- waiver residential habilitation,
- waiver day habilitation,
- waiver prevocational services,
- waiver supported employment,
- day treatment,
- respite,
- article 16, 28, or 31 clinics,
- fiscal/employer agent (CSS participants only)
- and others, (with the consent of the person)

HCBS Waiver habilitation providers (residential, day, prevocational, and supported employment) have 30 days from the date of the ISP review to make any necessary revisions to the habilitation plan and send the completed and revised plan to the service coordinator.

The service coordinator has 45 days from the date of the ISP review to send the full ISP or addendum and any revised habilitation plans to the consumer, advocate, and appropriate service providers. If the 45 day time frame cannot be met because of delays in obtaining the necessary signatures, the MSC service coordinator can send copies of the ISP to all parties without signatures. The ISP must be sent with a note indicating that the original document with the required signatures can be found in the individual's Service Coordination record.

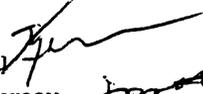
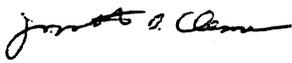




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TO: DDSO – HCBS Coordinators  
DDSO – Assistive Technology Coordinators

FROM: Kevin O'Dell, Waiver Management Bureau   
Jonathan Clement, Waiver Management Bureau 

DATE: May 20, 2005

SUBJECT: Advisory Memorandum - Assistive Technology (Environmental Modifications and Adaptive Devices)

### Background

Assistive Technology, also known as Environmental Modifications and Adaptive Devices, funded through the Home and Community-Based Services (HCBS) Waiver have been available to HCBS enrollees since 1991. Over the years, the definitions of approvable Environmental Modifications and Adaptive Devices have been further clarified. Attached are revised definitions, which should assist DDSO and NYCRO staff in their determination of allowable waiver services.

### Interim Direction

The advisory that follows provides direction on allowable Environmental Modifications and Adaptive Devices. The Risk Management Committee, which is comprised of Central Office and DDSO staff, is examining processes for contract approval and contract payment and will issue guidance to the field in these areas.

cc: Gary Lind  
Lisa Kagan  
Nancy Gendron  
Barbara Baciewicz  
Ross Hansen  
Allison McCarthy  
Carol Metevia  
Mary Tierney  
Maryhelen Lounello

# ASSISTIVE TECHNOLOGY

## I. Definitions

Assistive Technology is comprised of devices, pieces of equipment or physical plant modifications to a consumer's living environment that can help a person live independently and safely in the home of his or her choice, with the maximum possible control over their activities within the home and the community. An Assistive Technology, funded by the Home and Community Based Waiver, falls into one of two categories; **adaptive devices** and **environmental modifications** (e-mods)

### Adaptive Devices

Adaptive devices are aids, controls, appliances, or supplies - of either a communication or adaptive type - which enable the person to increase or maintain his or her ability to live at home and in the community with independence and safety. The devices assist the person in the performance of self-care, work, leisure activities and/or physical exercise. *Adaptive devices must be identified in the person's individualized service plan (ISP).*

### Allowable Adaptive Devices

The following items are considered to be "authorized reimburseables" through the HCBS Waiver (the list is not all inclusive):

#### A. Communication aids and devices, including:

- Personal emergency response systems which 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 Personal Emergency Response Systems (PERS) are also available under State Plan Medicaid with eligibility for PERS approved by the local social services district.*
- Direct selection, alpha-numeric, scanning, and encoding communicators.\*
- Speech amplifiers.\*
- Electronic speech aids/devices.
- Voice, light or motion activated electronic devices.\*

#### B. Adaptive aids and devices including:

- Standing boards/frames.\*
- Adaptive switches/devices.\*
- Feeding, dining, and meal preparation aids/devices/ appliances.\*
- Specially adapted locks.

- Motorized wheelchairs.\*
- Guide dogs and similar trained animals.
- 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, wheelchair and individual restraint systems, electrical safety interlock devices for lifts (transmission, ignition, etc.), stretcher stations (restraints, tautens), structural vehicle modifications (door height, door width, interior headroom, roof height, etc.), interior grab bars, skid-resistant floor coverings, exterior and interior lighting, and flip seating for ambulatory passengers who may be accompanying the person.
- Computer hardware and software that are used to assist a person with improving communication and/or adaptive skills.
- Adaptive aids and devices, other than the above, that would not otherwise be covered by the State Medicaid Plan.
- Custom-fitting and repairs to such adaptive devices (i.e. equipment) which are cost effective are also allowable.\* It is the DDSO's and service coordinator's responsibility, along with input from clinical or other qualified professional staff when appropriate, to determine the cost-effectiveness of such repairs and maintenance.

*\* These devices/services may be covered services 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 an approved Medicaid vendor who must get prior approval from the NYS Department of Health.*

Payment for a clinical assessment of the need for an adaptive device, for helping select a particular device, or for training in the use of a device, may be funded through the waiver as part of the cost of the Assistive Technology device if the expertise needed for these tasks is not available to the consumer as a part of:

- a) another Waiver habilitation service,
- or
- b) Medicaid State Plan Services; e.g., clinic

## **Environmental Modifications**

**Environmental Modifications (E-Mods)** are another form of Assistive Technology offered via the HCBS Waiver and are modifications and/or adaptations to the consumer's home physical environment. The environmental modification must result in a consumer's ability to live at home with independence. These modifications 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 identified in the person's individualized service plan (ISP).*

## Allowable Environmental Modifications

The following environmental modifications are considered to be “authorized reimburseables” through the HCBS Waiver (the list is not all inclusive):

- A. Modifications to address a person’s **physical** disabilities, allowing more safe and improved access and/or functioning within the home environment, including:
- Ramps.
  - Lifts (hydraulic, manual, or electrical) for porch, stairs, and/or bathroom.
  - Widened doorways/hallways.
  - Hand railings/grab bars.
  - Automatic or manual door openers/door bells.
  - Bathroom/kitchen modifications or adjustments, such as:
    - Roll-in showers.
    - Sinks/tubs.
    - Water faucet controls.
    - Plumbing adaptations (cut-outs, toilet/sink adaptations).
    - Turnaround space changes/adaptations.
    - Worktables/work surfaces adaptations.
    - Cabinet/shelving adaptations.
    - Shatter-proof bathroom/shower doors.
- B. Modifications that address a person’s **sensory deficits**, facilitating a safer environment, including:
- Braille identification systems.
  - Tactile orientation systems.
  - Bed shaker alarm devices.
  - Strobe light smoke detection and alarm devices.
- C. Modifications that promote a safer environment for people with **challenging behaviors**, including:
- Window protection.
  - Reinforcement of walls.
  - Open-door signal devices.
  - Durable wall finishes.

#### **D. Other adaptations including:**

- Medically necessary heating/cooling adaptations as required for medical treatment. (Adaptations utilized solely to improve a person's living environment do not qualify. In certified residential programs the cost of these adaptations is included as part of room and board costs and not considered E-Mods.)
- Electrical wiring to accommodate other adaptations or equipment installation.
- Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the person's welfare.
- 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 Waiver will fund environmental modifications that are essential to the consumer's health and safety and documented in the ISP. Examples of this include:
  - **Driveways: All Settings** - Driveways are considered items of general utility for a home; i.e., they are considered an ordinary component of any home. The waiver will fund driveways or a portion of a driveway only if the existing driveway does not allow the physically disabled person access to the home. The waiver will fund walkways from the driveway that are needed for the consumer to get safely to and from the vehicle and the home.
  - **Fences: All Settings** – the waiver may fund Fences only if it can be documented in the consumer's ISP that they are required for the safety and security of the consumer and are not being installed as an appearance item or for the convenience of staff or other family members. A fence may also be installed for an assistance animal for the disabled, blind or hearing impaired if required for the maintenance and security of the animal. The extent and type of fencing is at the discretion of the DDSO.
  - **Consumer Specific Items in New Rooms: All settings** - Items installed in new rooms that are related to a consumer's disability (e.g. roll-in showers, wheelchair accessible doors, modified cabinets, accessible sinks and faucets, etc.) are allowable environmental modifications. Generally, the cost of the room itself is not an allowable waiver eligible modification (see "New Rooms" below). Documentation submitted by the DDSO for environmental modifications that involve new rooms must clearly delineate the portion of the project that is Waiver eligible.

#### **Non-Allowable Environmental Modifications**

- **Home Additions** - OMRDD has established a policy that prohibits funding of additions for non-certified homes. A home addition is defined as any increase in the square footage of a home, any expansion beyond the existing footprint of the home, and construction of living space in a garage.

- **New Rooms** - Generally, new rooms are not Waiver fundable. Exceptions to this rule are outlined in the last paragraph of the Allowable Environmental Modifications section above (See "Consumer Specific Items in New Rooms" bullet). When an environmental modification requires construction or repairs that are not related to a consumer's disability, 100% State funds may be available. For example, in the case of a handicapped accessible bathroom, items that are not related to the consumer's disability such as: demolition of existing space, framing and sheetrocking of the new space, and any item required by building code could be paid using 100% State funds. Documentation submitted by the DDSO for environmental modifications that involve new rooms must clearly delineate items that are 100% State funded and Waiver funded.

## II. Assistive Technology and the Individualized Service Plan (ISP)

Any Assistive Technology to be funded through the HCBS Waiver must be specifically listed in the Waiver Services section of the consumer's Individualized Service Plan (ISP), as the Federal share for the cost of the Assistive Technology cannot be claimed if it is not listed in the ISP. The ISP, then, is the document required by Medicaid to support or justify any HCBS funded assistive technology. The ISP summarizes the help a consumer wants and needs to achieve his/her own aspirations in life and is considered to be a plan or blueprint from which all other plans generate. It is within the context of the ISP that a consumer's Assistive Technology needs are identified.

The ISP should be developed with input from the consumer, parent and/or advocate, the consumer's service coordinator and other appropriate professional (occupational therapy, physical therapy, medical, etc). Assistive Technology items that have been identified with limited input (e.g., the service coordinator and a parent only) will not be considered to have been appropriately developed and may result in the Assistive Technology project requiring further justification. It is important to note that an ISP is not intended to be a "wish list", comprised of those items or home modifications that a family would like, but which are not necessary to maintain the consumer in his/her home.

### APPENDIX

- A. **Residence Type: All Settings** - HCBS environmental modifications can be made only in a person's family home, a Community Residence, a Family Care Home, or an Individualized Residential Alternative. *If the applicant has been deemed eligible, but currently lives in an ICF/MR or other long-term care setting, the modifications may be completed prior to the individual's relocation to the new home.* The timing must be planned so that no more than 180 days passes between completion of work and the person's moving into the home.
- B. **New Development: Certified Residences** - With the current development of a great number of certified residences throughout the state, particularly in connection with the "New York State CARES" initiative, many of these new homes require environmental modifications in order to be safe and accessible.

The waiver will fund such items if:

1. They are not required by local codes, and
2. The ISPs for the people who will be living in the residence clearly support the need for such devices/construction. As there are a variety of ways that a residence can meet the safety and accessibility needs of consumers, it is expected that these will be accomplished in as cost effective a manner as possible. The waiver will not fund generic items that are not directly related to a person's disabilities such as the basic fire alarm/smoke detector system and ground fault interrupters that are required by local codes. It will fund some safety items that can be clearly supported by the individualized needs of a specific resident or residents. A strobe light attached to the fire alarm system, for example, would be a fundable item if a hearing impaired person lives in the residence and his or her ISP indicates the need for such a device.

3. Some other environmental modifications that the waiver will fund are:

The portions of design fees that can be attributed to the environmental modifications, and

The appropriate portion of payments made to cover contingency costs.

4. The waiver will not pay for performance bond expenditures as these costs are too far removed from the actual environmental modification items.
5. The waiver will not fund extra large rooms, wider hallways, and extra large bathrooms in new construction. It will only fund the items installed in these spaces that are related to the disabilities of the consumers such as handrails, grab bars, accessible bathroom fixtures, etc.

**C. Unrelated Construction: All Settings** - HCBS environmental modifications may not be used to underwrite construction costs unless those costs are clearly tied to the items or modifications that are being provided to improve access and self-reliance. Modifications may not alter the existing "footprint" of the home. (See Home Additions below).

**D. One-Time-Only Exceptions: All Settings** - 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 which were previously provided may be granted if movement to a new home or certified residence occurs because of circumstances related to the consumer's health, welfare or safety, or other situations beyond the consumer's control. Exceptions may also be granted in circumstances where the person lives alternately in separate parental residences.

- E. Replacements: All Settings** - 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.
- F. Building Codes/Zoning Laws: All Settings** - *Providers of environmental modifications must ensure that their work meets the requirements of all applicable building codes including the New York State Uniform Fire Prevention and Building Code, the Building Code Of The City Of New York, local codes, and all applicable local zoning laws.* Building permits must be obtained whenever required, from OMRDD for State-owned properties, and from local building officials for family homes and voluntary provider operated properties. The waiver will not fund items that are required by local code.
- G. Construction Materials: All Settings** - Materials funded by the HCBS Waiver for Environmental Modifications should be “construction grade”; i.e., materials of good quality that will accomplish the job at an average cost.
- H. New Construction/Funding “Larger” Residence: All Settings** - In the waiver agreement, the federal government specifically states that environmental modifications “cannot add to the total square footage of a home”. Thus Medicaid funds cannot be used to fund the increase in real estate value that would result from increasing the overall footprint of the home whether it be a family home or new residence. The waiver will therefore not fund any portion of the footprint of a home or new residence. It will however fund ramps and other items needed by the consumers who will be living in the home or new residence (see page 3).



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**ADMINISTRATIVE MEMORANDUM - #2006-01**

**TO:** Executive Directors of Agencies Authorized to Provide Group Day Habilitation Services  
Executive Directors of Agencies Authorized to Provide Medicaid Service Coordination  
DDSO Directors

**FROM:** Helene DeSanto, Executive Deputy Commissioner  
and Interim Director, Quality Assurance *Helene DeSanto*

Gary Lind, Director  
Policy, Planning and Individualized Initiatives *Gary Lind*

James B. Moran, Deputy Commissioner  
Administration and Revenue Support *J. Moran*

**SUBJECT: GROUP DAY HABILITATION SERVICE DOCUMENTATION REQUIREMENTS**

**DATE: January 1, 2006**

**Suggested Distribution:**

Group Day Habilitation Program/Service Staff  
Quality/Compliance Staff  
Billing Department Staff  
MSC Service Coordinators and Service Coordinator Supervisors

**Purpose:**

This is to review the Group Day Habilitation service documentation requirements that support a provider's claim for reimbursement. These service documentation criteria apply to Group Day Habilitation services rendered to Home and Community Based Services (HCBS) waiver-enrolled individuals as well as to non-waiver enrolled individuals effective January 1, 2006. Requirements set forth in this Administrative Memorandum supersede Administrative Memorandum 2003-04 and fiscal audit service documentation requirements addressed in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD, 1997). Quality service standards in The Key remain the same.

ADMINISTRATIVE MEMORANDUM #2006-01  
Group Day Habilitation Service Documentation Requirements  
January 1, 2006

**Background:**

18 NYCRR, Section 504.3(a) states that by enrolling in the Medicaid program, “the provider agrees...to prepare and to **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.” (emphasis added) It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for HCBS Waiver Group Day Habilitation is in 14 NYCRR section 635-10.4 (b)(2) and 635-10.5 (c)

**Group Day Habilitation Services:**

Effective January 1, 2006, for billing purposes, Day Habilitation will be categorized as Group Day Habilitation, Supplemental Group Day Habilitation, Individual Day Habilitation or Supplemental Individual Day Habilitation services. All four forms of Day Habilitation conform to the existing service definitions in 14 NYCRR section 635-10.4 (b)(2).

This memorandum describes the service documentation requirements for Group Day Habilitation and Supplemental Group Day Habilitation. Group Day Habilitation services are services that are generally provided to two or more consumers, although one-to-one services may also be provided. Group Day Habilitation services are provided on weekdays with a service start time prior to 3:00 p.m. Supplemental Group Day Habilitation are services that are delivered anytime on Saturday or Sunday, or on weekdays with a service start time of 3:00p.m. or later

Supplemental services billed separately to Medicaid or OMRDD are designed for consumers who live at home, in Supportive IRAs, in Supportive CRs or Family Care Homes. Supplemental Group Day Habilitation services may not be separately billed to Medicaid or OMRDD for consumers who live in residences with 24-hour staffing (e.g., Supervised IRAs or Supervised CRs). It is the responsibility of a residence with 24-hour staffing to provide residential habilitation services on weekday evenings and weekends.

**Billing Standard:**

Payment for Group Day Habilitation and Supplemental Group Day Habilitation requires for each consumer served, prior authorization from the DDSO/NYCRO. Service providers which have been authorized to provide Supplemental Group Day Habilitation must correctly categorize their services as “Supplemental Group Day Habilitation” vs. “Group Day Habilitation” based on these time parameters and must use the appropriate billing rate code for each.

## ADMINISTRATIVE MEMORANDUM #2006-01

### Group Day Habilitation Service Documentation Requirements

January 1, 2006

Group Day Habilitation and Supplemental Group Day Habilitation services are billed as either a Full Unit or a Half Unit. A Full Unit may be billed when staff deliver and document at least two individualized face-to-face Group Day Habilitation services to a consumer during the program day, and the program day duration is four to six hours in duration. A Half Unit of Group Day Habilitation or Supplemental Group Day Habilitation may be billed when staff deliver and document at least one individualized face-to-face Group Day Habilitation service to a consumer during the program day, and the program day duration is at least two hours.

For both Group Day Habilitation and Supplemental Group Day Habilitation the *program day duration* is defined as the length of time the provider delivers face-to-face Group Day Habilitation services to the person. Time spent in the following activities cannot be counted toward the program day duration:

- Time the consumer spends being transported to the first Group Day Habilitation activity of the day and time being transported home or to the next activity after the conclusion of Group Day Habilitation services.
- Time the consumer spends at a separate service (e.g., a clinic service) and the time being transported to and from the separate service.

Note: The provision of Medicaid Service Coordination (MSC) is the only exception to the rule regarding “backing out” time at another Medicaid service from the Day Habilitation program day. Time the consumer spends with his/her MSC Service Coordinator can be counted toward the Group Day Habilitation or Supplemental Group Day Habilitation program day as long as the visit occurs at a Day Habilitation service location. Also, the consumer’s time at the ISP review conducted by the MSC Service Coordinator may count toward the Day Habilitation program day duration as long as the Day Habilitation staff accompany the consumer to the meeting.

- Mealtime.

Day Habilitation services delivered during mealtimes, while at a clinic or during travel specified above, cannot be used to meet the billing requirements for a Full or Half Unit. While services provided at these times are important to service quality, they cannot be used to fulfill the billing requirement of two services for a Full Unit or one service for a Half Unit.

#### **Service Documentation:**

**Medicaid rules require that service documentation be contemporaneous with the service provision.**

Required service documentation elements are:

1. **Consumer’s name and Medicaid number (CIN).** Note that the CIN need not be included in daily documentation; rather, it can appear in the consumer’s Group Day Habilitation Plan.

ADMINISTRATIVE MEMORANDUM #2006-01  
Group Day Habilitation Service Documentation Requirements  
January 1, 2006

2. **Identification of category of waiver service provided.** Although the waiver service is identified as “Group Day Habilitation” or “Supplemental Group Day Habilitation” for billing and service documentation purposes, the consumer’s Individualized Service Plan (ISP) should identify the category of waiver service as “Day Habilitation.”
3. **A daily description of the required minimum number of face-to-face services provided by staff.** Face-to-face services are individualized services based on the person’s Group Day Habilitation Plan, e.g., the staff person documents that he/she “taught the person how to count change up to one dollar.” The number of face-to-face services required to support billing depends on the unit billed and is described in the above section titled “Billing Standards.”
4. **Documentation that the minimum service duration requirement was met.**
  - **For Group Day Habilitation,** the provider may document the *program day duration* by indicating the service start time and service stop time. Alternatively, the provider may elect to document the program day duration with a daily affirmation, stating that the minimum duration was met in either a narrative note or checklist format, e.g., “*I attest that a 4-hour program day was provided today to John Smith. Sally Jones, Group Day Habilitation Worker, January 12, 2006.*” Note that where a provider does not document service start and service stop time, an outside reviewer may require other documentation that supports the service duration, for example, a bus log that demonstrates the consumer was at a Group Day Habilitation site for at least 4 hours.
  - **For Supplemental Group Day Habilitation,** the provider must document the service start time and the service stop time.

In addition to documenting the program day duration, when a consumer attends another service during the Group Day Habilitation or Supplemental Group Day Habilitation program day, such as a clinic service or doctor’s appointment, the provider must document the “clock” time of the consumer’s departure from the Group Day Habilitation program and the time the consumer returned.

5. **The consumer’s response to the service.** For example, the staff person documents that “after several practice sessions the consumer was able to count the change he received after purchasing a magazine.” Note that at a minimum, the consumer response must be documented in a monthly summary note, although a provider may choose to include the consumer response more frequently, e.g. daily.
6. **The date the service was provided.**
7. **The primary service location,** e.g., “Maple Avenue Group Day Habilitation” or “without walls,” if services are provided at changing locations in the community and there is no primary service location.
8. **Verification of service provision by the Group Day Habilitation staff person delivering the service.** Initials are permitted if a “key” is provided, which identifies the title, signature and full name associated with the staff initials.

ADMINISTRATIVE MEMORANDUM #2006-01  
Group Day Habilitation Service Documentation Requirements  
January 1, 2006

9. **The signature and title of the Group Day Habilitation staff person documenting the service.**
10. **The date the service was documented.** Note that this date must be concurrent with service provision.

The acceptable format for the service documentation supporting a provider's billing submittal is either a narrative note or a checklist/chart with an entry made at the same time each Group Day Habilitation service is delivered and billed.

Narrative Note Format

If the narrative note format is selected, the documentation can be completed in one of two ways:

1. A daily service note describing at least two face-to-face individualized services delivered by Group Day Habilitation staff on each day the provider bills a Full Unit of either Group Day Habilitation or Supplemental Group Day Habilitation. At least one face-to-face individualized service delivered by Group Day Habilitation staff must be documented on each day the provider bills a Half Unit of either Group Day Habilitation or Supplemental Group Day Habilitation. Since the daily note does not include the consumer's response to the service, a monthly summary note is required. This monthly note must summarize the implementation of the individual's Group Day Habilitation Plan, address the consumer's response to the services provided and any issues or concerns; **OR**
2. On each day the provider bills a Full Unit of either Group Day Habilitation or Supplemental Group Day Habilitation, a daily service note describing at least two face-to-face individualized services delivered by Day Habilitation staff and the consumer's response to the service. On each day the provider bills a Half Unit of either Group Day Habilitation or Supplemental Group Day Habilitation, a daily service note describing at least one face-to-face individualized service delivered by Group Day Habilitation staff and the consumer's response to the service delivery. Additionally, at least one of the daily notes written during the month must summarize the implementation of the individual's Group Day Habilitation Plan and address any issues or concerns.

Checklist / Chart Format

For each day service is delivered, a provider may elect to document the required face-to-face individualized Group Day Habilitation and Supplemental Group Day Habilitation service delivered by Group Day Habilitation staff using a checklist or chart. If this format is selected, a monthly summary note is also required. The monthly summary note must summarize the implementation of the individual's Group Day Habilitation Plan; address the consumer's response to services provided and any issues or concerns.

**Both the Narrative Note format and the Checklist/Chart format must include all the Service Documentation elements listed above, including a description of the required minimum number of face-to-face individualized services provided by Day Habilitation staff each day the provider bills either Group Day Habilitation or Supplemental Group Day Habilitation.**

**Other Documentation Requirements:**

In addition to the service note(s) supporting Group Day Habilitation or Supplemental Group Day Habilitation billing claims, your agency 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 Coordinator (MSC) or Plan of Care Support Services (PCSS) service coordinator. Although for billing and service documentation purposes we distinguish between the four types of Day Habilitation (i.e., Individual Day Habilitation, Supplemental Individual Day Habilitation, Group Day Habilitation or Supplemental Group Day Habilitation), the ISP should identify the category of waiver service as "Day Habilitation." The ISP, which is the "authorization" for waiver services, must also identify your agency as the provider of the service. Further, the ISP must specify an effective date for Day Habilitation that is on or before the first date of service for which your agency bills Day Habilitation for the consumer. The ISPs should identify the frequency for Group Day Habilitation and Supplemental Group Day Habilitation as "a *day*".
- ✓ The **Group Day Habilitation Plan** developed by your agency that conforms to the Habilitation Plan requirements found in ADM 2003-03. For both Group Day Habilitation and Supplemental Group Day Habilitation the Habilitation Plan is entitled "Group Day Habilitation Plan". The Group Day Habilitation Plan must "cover" the time period of the Group Day Habilitation service claim. Note that the consumer's Group Day Habilitation Plan is attached to his/her ISP. If a consumer attends both Group and Supplemental Group Day Habilitation Services, you may maintain one Group Day Habilitation Plan. This plan must, however, have a separate section that clearly identifies the supports and services associated with Group Day Habilitation and a separate section that clearly identifies the supports and services associated with Supplemental Group Day Habilitation.

**Documentation Retention:**

All documentation specified above, including the ISP, Group Day 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 Day Habilitation claim for a sampled consumer will be selected and the auditor will typically ask for the ISP and Group Day Habilitation Plan in effect for the claim date. The auditor will also require, for the claim dates, the service documentation specified above.

For additional information on the documentation requirements or to request samples of documentation checklist formats, contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408-2096, or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

ADMINISTRATIVE MEMORANDUM #2006-01  
Group Day Habilitation Service Documentation Requirements  
January 1, 2006

cc: Provider Associations  
Kathy Broderick  
Michele Gatens  
Carol Metevia  
Kevin O'Dell  
David Picker





STATE OF NEW YORK  
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**ADMINISTRATIVE MEMORANDUM - #2006-02**

**TO:** Executive Directors of Agencies Authorized to Provide Individual Day Habilitation Services  
Executive Directors of Agencies Authorized to Provide Medicaid Service Coordination  
DDSO Directors

**FROM:** Helene DeSanto, Executive Deputy Commissioner and Interim Director Quality Assurance *Helene DeSanto*  
Gary Lind, Director Policy, Planning and Individualized Initiatives *Gary Lind*  
James F. Moran, Deputy Commissioner Administration and Revenue Support *JFM*

**SUBJECT:** INDIVIDUAL DAY HABILITATION SERVICE DOCUMENTATION REQUIREMENTS

**DATE:** January 1, 2006

**Suggested Distribution:**

Individual Day Habilitation Program/Service Staff  
Quality/Compliance Staff  
Billing Department Staff  
MSC Service Coordinators and Service Coordinator Supervisors

**Purpose:**

This is to review the Day Habilitation service documentation requirements that support a provider's claim for reimbursement. These service documentation criteria apply to *Individual* Day Habilitation services rendered to Home and Community Based Services (HCBS) waiver-enrolled individuals as well as to non-waiver enrolled individuals effective January 1, 2006. Requirements set forth in this Administrative Memorandum

ADMINISTRATIVE MEMORANDUM #2006-02  
Individual Day Habilitation Service Documentation Requirements  
January 1, 2006

supersede Administrative Memorandum 2003-04 and fiscal audit service documentation requirements addressed in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD, 1997). Quality service standards in The Key remain the same.

**Background:**

18 NYCRR, Section 504.3(a) states that by enrolling in the Medicaid program, “the provider agrees...to prepare and to **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.” (emphasis added) It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for HCBS Waiver Individual Day Habilitation is in 14 NYCRR section 635-10.4 (b)(2) and 635-10.5 (c)

**Individual Day Habilitation Services:**

Effective January 1, 2006, for billing purposes, Day Habilitation will be categorized as Group Day Habilitation, Supplemental Group Day Habilitation, Individual Day Habilitation or Supplemental Individual Day Habilitation services. All four forms of Day Habilitation conform to the existing service definitions in 14 NYCRR section 635-10.4 (b)(2).

This memorandum describes the service documentation requirements for Individual and Supplemental Individual Day Habilitation. **Individual Day Habilitation services are provided to a single enrolled consumer with at least one staff person providing services to no more than one consumer for the duration of the service.** Individual Day Habilitation services are delivered on weekdays with a service start time prior to 3:00 p.m.

Supplemental Individual Day Habilitation are services that are delivered anytime on Saturday or Sunday, or on weekdays with a service start time of 3:00 p.m. or later. Supplemental Individual Day Habilitation service may not be separately billed to Medicaid or OMRDD for consumers who live in residences with 24-hour staffing (e.g., Supervised IRAs or Supervised CRs). It is the responsibility of a residence with 24-hour staffing to provide residential habilitation services on weekday evenings and weekends.

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Individual Day Habilitation Service Documentation Requirements  
January 1, 2006

**Billing Standard:**

The unit of service for Individual Day Habilitation and Supplemental Individual Day Habilitation services is an hour. Services are billed in 15-minute increments, with a full 15 minutes of service required to bill a single increment (i.e., there is no “rounding up”). Payment for Individual Day Habilitation or Supplemental Individual Day Habilitation requires, for each consumer served, prior authorization from the DDSO/NYCRO.

For each continuous period of service delivery (or “session”), the provider must document the delivery of at least one individualized, face-to-face service provided by Individual Day Habilitation staff that is based on the consumer’s Individual Day Habilitation Plan. The provider must also document the service start time and service stop time for each Individual Day Habilitation or Supplemental Individual Day Habilitation “session.”

The *billable service time* for Individual Day Habilitation and Supplemental Individual Day Habilitation is the time when Individual Day Habilitation staff are providing one-on-one, face-to-face Individual Day Habilitation services to a consumer. Time spent in the following activities cannot be counted toward the billable service time:

- **Time the consumer spends in group activities must be excluded when determining the number of quarter hours billed.** Group activities are activities that include two or more consumers. For example, if a staff person accompanies two consumers to the local mall to work on money management skills, this time is not “countable” as billable service time for Individual Day Habilitation.
- **Time at another service** (e.g., a clinic service or a medical appointment) and time being transported to and from the other service does not count in determining the number of quarter-hours to be billed toward the Individual Day Habilitation billable service time.

Note: Medicaid Service Coordination (MSC) is the only exception to the rule regarding other services being “backed out” of the Individual Day Habilitation billable service time. Time the consumer spends with his/her MSC Service Coordinator during the MSC monthly visit and at ISP reviews may be included as Individual Day Habilitation billable service time as long as Day Habilitation staff accompany the consumer to the meetings.

- **Transportation** to the first “out-of-home” activity of the day and transportation after the last “out-of-home” Individual Day Habilitation activity of the day does not count in determining the time that is to be billed. For example, an Individual Day Habilitation staff person picks up the consumer at his or her home at 9 a.m.

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The consumer and the staff person travel to the local library where Day Habilitation services begin at 9:30 a.m. The two are engaged in Individual Day Habilitation activities from 9:30 until 1:00 p.m., at which time they travel to the Gym and continue Individual Day Habilitation services. At 3:00 p.m. Individual Day Habilitation services conclude for the day when the Individual Day Habilitation staff person and the consumer leave the Gym to travel to the consumer's home. In this case, the billable service time for the day is 5 ½ hours (or 22 quarter hours). The 5 ½ hours begins at the time the consumer accompanied by Individual Day Habilitation Staff, arrived at the first "out-of-home" Individual Day Habilitation site (the Library) through the conclusion of services at the Gym. The time being transported from home to the Library and from the Gym to home is not "billable service time." The "internal" or Day Habilitation "site to site" transportation time (i.e., the time spent being transported from the Library to the Gym) is "countable" toward the billable service time.

Note: There is one exception to the prohibition on counting as billable service time, the time spent in transport to the first service location of the day and back from the last activity of the day. If Individual Day Habilitation staff provide travel training during these transportation times, this time may be counted as long as the travel training is **time limited** and is specified in the consumer's Individual Day Habilitation Plan.

**Service Documentation:**

**Medicaid rules require that service documentation be contemporaneous with the service provision.** Required service documentation elements are:

1. **Consumer's name and Medicaid number (CIN).** Note that the CIN need not be included in daily documentation; rather, it can appear in the consumer's Individual Day Habilitation Plan.
2. **Identification of category of waiver service provided.** Although the waiver service is identified as "Individual Day Habilitation" or "Supplemental Individual Day Habilitation" for billing and service documentation purposes, the consumer's Individualized Service Plan (ISP) should identify the category of waiver service as "Day Habilitation."
3. **A daily description of at least one face-to-face service provided by staff during each "session" (or continuous period of Individual Day Habilitation service provision).** Face-to-face services are individualized services based on the person's Individual Day Habilitation Plan, e.g., the staff person documents that he/she "taught the person to select reading material at the library."

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January 1, 2006

4. **Documentation of start and stop times.** The provider must document the service start time and service stop time for each continuous period of Individual Day Habilitation service provision or "session."
5. **The consumer's response to the service.** For example, the staff person documents that "consumer was able to present his library card to check out periodicals." Note that at a minimum, the consumer response must be documented in a monthly summary note, although a provider may choose to include the consumer response more frequently, e.g. daily.
6. **The date the service was provided.**
7. **The primary service location, e.g., "Maple Avenue Library" or "Various Community Locations."**
8. **Verification of service provision by the Individual Day Habilitation staff person delivering the service.** Initials are permitted if a "key" is provided, which identifies the title, signature and full name associated with the staff initials.
9. **The signature and title of the Individual Day Habilitation staff person documenting the service.**
10. **The date the service was documented.** Note that this date must be concurrent with service provision.

The acceptable format for the service documentation supporting a provider's billing submittal is either a narrative note or a checklist/chart with an entry made at the same time each Individual Day Habilitation service is delivered and billed.

Narrative Note Format

If the narrative note format is selected, the documentation can be completed in one of two ways:

1. A daily service note describing at least one face-to-face individualized service delivered by Individual Day Habilitation staff for each Individual Day Habilitation or Supplemental Individual Day Habilitation "session." The note does not include the consumer's response to the service. If this format is selected, a monthly summary note is required. This monthly note must summarize the implementation of the consumer's Individual Day Habilitation Plan, address the consumer's response to the services provided and any issues or concerns; **OR**

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January 1, 2006

2. A daily service note describing at least one face-to-face individualized service delivered by Individual Day Habilitation staff for each Individual Day Habilitation or Supplemental Individual Day Habilitation “session” and the consumer’s response to the service delivery. Additionally, at least one of the daily notes written during the month must summarize the implementation of the person’s Individual Day Habilitation Plan and address any issues or concerns.

Checklist / Chart Format

For each service session, a provider may elect to document the face-to-face Individual Day Habilitation or Supplemental Individual Day Habilitation service delivered by Individual Day Habilitation staff using a checklist or chart. If this format is selected, a monthly summary note is also required. The monthly summary note must summarize the implementation of the consumer’s Individual Day Habilitation Plan; address the consumer’s response to services provided and any issues or concerns.

**Both the Narrative Note format and the Checklist/Chart format must include all the Service Documentation elements listed above, including a description of at least one face-to-face individualized service provided by Individual Day Habilitation staff for each Individual Day Habilitation session. The start and stop time for each Individual Day Habilitation “session” must also be documented.**

**Other Documentation Requirements:**

In addition to the service note(s) supporting the Individual Day Habilitation billing claim, your agency 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 Coordinator (MSC) or Plan of Care Support Services (PCSS) service coordinator. Although for billing purposes we distinguish between the four types of Day Habilitation (i.e., Individual Group Day Habilitation, Supplemental Individual Day Habilitation, Group Day Habilitation or Supplemental Group Day Habilitation), the ISP identifies the category of waiver service as “Day Habilitation.” The ISP must also identify your agency as the Day Habilitation provider. The ISP must specify an effective date for Day Habilitation that is on or before the first date of service for which your agency bills Individual Day Habilitation or Supplemental Individual Day Habilitation for the consumer. The frequency for Individual Day Habilitation and Supplemental Individual Day Habilitation is an *hour*.
- ✓ The **Individual Day Habilitation Plan** developed by your agency that conforms to the Habilitation Plan requirements found in ADM 2003-03. For both Individual Day Habilitation and Supplemental Individual Day Habilitation the Habilitation Plan is

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January 1, 2006

entitled "Individual Day Habilitation Plan". The Individual Day Habilitation Plan must "cover" the time period of the Individual Day Habilitation service claim. Note that the consumer's Individual Day Habilitation Plan is attached to his/her ISP. If a consumer attends both Individual and Supplemental Individual Day Habilitation Services, you may maintain one Individual Day Habilitation Plan. This plan must, however, have a separate section that clearly identifies the supports and services associated with Individual Day Habilitation and a separate section that clearly identifies the supports and services associated with Supplemental Individual Day Habilitation.

**Documentation Retention:**

All documentation specified above, including the ISP, Individual Day 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 Day Habilitation claim for a sampled consumer will be selected and the auditor will typically ask for the ISP and Individual Day Habilitation Plan in effect for the claim date. The auditor will also require, for the claim dates, the service documentation specified above.

For additional information on the documentation requirements or to request samples of documentation checklist formats, contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408-2096, or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

cc: Provider Associations  
Kathy Broderick  
Michele Gatens  
Carol Metevia  
Kevin O'Dell  
David Picker



George E. Pataki  
Governor



Thomas A. Maul  
Commissioner

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**ADMINISTRATIVE MEMORANDUM - #2006-03**

**TO:** Executive Directors of Agencies Authorized to Provide Prevocational Services  
Services  
Executive Directors of Agencies Authorized to Provide Medicaid Service  
Coordination  
DDSO Directors

**FROM:** Helene DeSanto, Executive Deputy Commissioner  
and Interim Director, Quality Assurance *Helene DeSanto*

Gary Lind, Director *Gary Lind*  
Policy, Planning and Individualized Initiatives

James F. Moran, Deputy Commissioner *JFM*  
Administration and Revenue Support

**SUBJECT:** SERVICE DOCUMENTATION REQUIREMENTS FOR PREVOCATIONAL  
SERVICES

**DATE:** January 1, 2006

**Suggested Distribution:**

Prevocational Services Program/Service Staff  
Quality/Compliance Staff  
Billing Department Staff  
MSC Service Coordinators and Service Coordinator Supervisors

**Purpose:**

This is to review the Prevocational Services service documentation requirements that support a provider's claim for reimbursement. These service documentation criteria apply to Prevocational Services rendered to Home and Community Based Services (HCBS) waiver-enrolled individuals as well as to non-waiver enrolled individuals effective January 1, 2006. Requirements set forth in this Administrative Memorandum supersede Administrative Memorandum 2003-05 and fiscal audit service documentation requirements addressed in The Key to Individualized Services, The Home and Community Based Services Waiver (OMRDD, 1997). Quality service standards in The Key remain the same.



ADMINISTRATIVE MEMORANDUM #2006-03  
Service Documentation Requirements for Prevocational Services  
January 1, 2006

**Background:**

18 NYCRR, Section 504.3(a) states that by enrolling in the Medicaid program, “the provider agrees...to prepare and to **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.” (emphasis added) It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OMRDD.

The regulatory basis for HCBS Waiver Prevocational Services is in 14 NYCRR section 635-10.4 (c) and 635-10.5 (e).

**Prevocational Services Billing Standard:**

Payment for Prevocational Services requires for each consumer served, prior authorization from the DDSO/NYCRO. Prevocational Services are billed as either a Full Unit or a Half Unit. A Full Unit may be billed when staff deliver and document at least two individualized face-to-face Prevocational Services to a consumer during the program day, and the program day duration is four to six hours in duration. A Half Unit of Prevocational Services may be billed when staff deliver and document at least one individualized face-to-face Prevocational Service to a consumer during the program day, and the program day duration is at least two hours.

For Prevocational Services the *program day duration* is defined as the length of time the consumer attends the provider’s “vocational/work program.” In cases where the provider’s Prevocational Services are delivered outside a “vocational/work program” setting, the *program day duration* is the length of time that staff provide face-to-face Prevocational Services to the consumer. Time spent in the following activities cannot be counted toward the program day duration:

- Time the consumer spends being transported to the first Prevocational Services activity of the day and time being transported home or to the next activity after the conclusion of Prevocational Services.
- Time the consumer spends at a separate service (e.g., a clinic service) and the time being transported to and from the separate service.

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Service Documentation Requirements for Prevocational Services  
January 1, 2006

Note: The provision of Medicaid Service Coordination (MSC) is the only exception to the rule regarding other services being “backed out” of the Prevocational Services Program Day. Time the consumer spends meeting with his/her MSC Service Coordinator may be counted toward the Prevocational Services Program Day as long as the visit occurs at the Prevocational Services site. Also, the consumer’s time at the ISP review conducted by the MSC Service Coordinator may be counted toward the Prevocational Program Day duration as long as the Prevocational Services staff accompany the consumer to the meeting.

- Mealtime.

Prevocational Services delivered during mealtimes, while at a clinic or during travel specified above, cannot be used to meet the billing requirements for a Full or Half Unit. While services provided at these times are important to service quality, they cannot be used to fulfill the billing requirement of two services for a Full Unit or one service for a Half Unit.

#### **Service Documentation:**

**Medicaid rules require that service documentation be contemporaneous with the service provision.** Required service documentation elements are:

1. **Consumer’s name and Medicaid number (CIN).** Note that the CIN need not be included in daily documentation; rather, it can appear in the consumer’s Prevocational Services Plan.
2. **Identification of category of waiver service provided.** The consumer’s Individualized Service Plan (ISP) should identify the category of waiver service as “Prevocational Services.”
3. **A daily description of the required minimum number of face-to-face services provided by staff.** Face-to-face services are individualized services based on the person’s Prevocational Services Plan, e.g., the staff person documents that he/she “taught the consumer how to return from breaks by using his watch to keep track of time.” The number of face-to-face services required to support billing depends on the unit billed and is described in the above section titled “Billing Standards.”
4. **Documentation that the minimum service duration requirement was met.** For Prevocational Services, the provider may document the *program day duration* by indicating the service start time and service stop time. Alternatively, the provider may elect to document the program day duration with a daily affirmation, stating that the minimum duration was met in either a narrative note or checklist format, e.g., “*I attest that a 4-hour program day was provided today to John Smith. Sally Jones, Prevocational Services Worker, January 12, 2006.*” Note that where a provider does not

ADMINISTRATIVE MEMORANDUM #2006-03  
Service Documentation Requirements for Prevocational Services  
January 1, 2006

document service start and service stop time, an outside reviewer may require other documentation that supports the service duration, for example, a bus log that demonstrates the consumer was at a Prevocational Services site for at least 4 hours. In addition to documenting the program day duration, when a consumer attends another service during the Prevocational Services program day, such as a clinic service or doctor's appointment, the provider must document the "clock" time of the consumer's departure from the Prevocational Services program and the time the consumer returned.

5. **The consumer's response to the service.** For example, the staff person documents that "the consumer is returning from breaks on time." Note that at a minimum, the consumer response must be documented in a monthly summary note, although a provider may choose to include the consumer response more frequently, e.g. daily.
6. **The date the service was provided.**
7. **The primary service location**, e.g., "Maple Avenue Prevocational Services" or "without walls," if services are provided at changing locations in the community and there is no primary service location.
8. **Verification of service provision by the Prevocational Services staff person delivering the service.** Initials are permitted if a "key" is provided, which identifies the title, signature and full name associated with the staff initials.
9. **The signature and title of the Prevocational Services staff person documenting the service.**
10. **The date the service was documented.** Note that this date must be concurrent with service provision.

The acceptable format for the service documentation supporting a provider's billing submittal is either a narrative note or a checklist/chart with an entry made at the same time each Prevocational Services service is delivered and billed.

Narrative Note Format

If the narrative note format is selected, the documentation can be completed in one of two ways:

1. A daily service note describing at least two face-to-face individualized services delivered by Prevocational Services staff on each day the provider bills a Full Unit of Prevocational Services. At least one face-to-face individualized service delivered by Prevocational Services staff must be documented on each day the provider bills a Half Unit of Prevocational Services. Since the daily note does not include the consumer's response to the service, a monthly summary note is required. This monthly note must summarize the implementation of the individual's Prevocational Services Plan, address the consumer's response to the services provided and any issues or concerns; **OR**
2. On each day the provider bills a Full Unit of Prevocational Services, a daily service note describing at least two face-to-face individualized services delivered by Prevocational Services staff and the

## ADMINISTRATIVE MEMORANDUM #2006-03

Service Documentation Requirements for Prevocational Services  
January 1, 2006

consumer's response to the service. On each day the provider bills a Half Unit of Prevocational Services, a daily service note describing at least one face-to-face individualized service delivered by Prevocational Services staff and the consumer's response to the service delivery. Additionally, at least one of the daily notes written during the month must summarize the implementation of the individual's Prevocational Services Plan and address any issues or concerns.

### Checklist / Chart Format

For each day service is delivered, a provider may elect to document the required face-to-face individualized Prevocational Services delivered by Prevocational Services staff using a checklist or chart. If this format is selected, a monthly summary note is also required. The monthly summary note must summarize the implementation of the individual's Prevocational Services Plan; address the consumer's response to services provided and any issues or concerns.

**Both the Narrative Note format and the Checklist/Chart format must include all the Service Documentation elements listed above, including a description of the required minimum number of face-to-face individualized services provided by Prevocational Services staff each day the provider bills Prevocational Services.**

### **Other Documentation Requirements:**

In addition to the service note(s) supporting Prevocational Services billing claims, your agency 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 Coordinator (MSC) or Plan of Care Support Services (PCSS) service coordinator. The ISP should identify the category of waiver service as "Prevocational Services." The ISP, which is the "authorization" for waiver services, must also identify your agency as the provider of the service. Further, the ISP must specify an effective date for Prevocational Services that is on or before the first date of service for which your agency bills Prevocational Services for the consumer. The ISPs should identify the frequency for Prevocational Services as "a day".
- ✓ The **Prevocational Services Plan** developed by your agency that conforms to the Habilitation Plan requirements found in ADM 2003 -03. The Prevocational Services Plan must "cover" the time period of the Prevocational Services claim. Note that the consumer's Prevocational Services Plan is attached to his/her ISP.

### **Documentation Retention:**

All documentation specified above, including the ISP, Prevocational Services 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.

**ADMINISTRATIVE MEMORANDUM #2006-03**  
**Service Documentation Requirements for Prevocational Services**  
**January 1, 2006**

**Fiscal Audit:**

In a fiscal audit a Prevocational Services claim for a sampled consumer will be selected and the auditor will typically ask for the ISP and Prevocational Services Plan in effect for the claim date. The auditor will also require, for the claim dates, the service documentation specified above.

For additional information on the documentation requirements or to request samples of documentation checklist formats, contact Ms. Carol Metevia, Director of Training and Medicaid Standards at (518) 408-2096, or Mr. Kevin O'Dell, Director of Waiver Management at (518) 474-5647.

cc: Provider Associations  
Kathy Broderick  
Michele Gatens  
Carol Metevia  
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**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 B. 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

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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

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Family Care Residential Habilitation Service Documentation Requirements

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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



# Family Care Residential Habilitation Plan

DDSO/Sponsoring Agency \_\_\_\_\_

Address \_\_\_\_\_

Medicaid Service Coordinator \_\_\_\_\_

Review Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Family Care Provider/Co-Provider Name \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Medicaid CIN# \_\_\_\_\_ TABS ID # \_\_\_\_\_

Outcomes/Support	Provider Activities	Schedule

Plan developed by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

# Family Care Residential Habilitation Plan Health & Safety Needs

Name \_\_\_\_\_

Medicaid CIN # \_\_\_\_\_ TABS ID # \_\_\_\_\_

Behavior \_\_\_\_\_

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Medical \_\_\_\_\_

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Fire Safety \_\_\_\_\_

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Level of Supervision both in the home and in the community \_\_\_\_\_

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Other Needs \_\_\_\_\_

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Developed by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

# HCBS WAIVER SERVICE DOCUMENTATION

## AGENCY SPONSORED FAMILY CARE RESIDENTIAL HABITATION DAILY CHECKLIST

AGENCY: \_\_\_\_\_ FAMILY CARE PROVIDER: \_\_\_\_\_ (Print Name)

CONSUMER NAME: \_\_\_\_\_ FAMILY CARE CO-PROVIDER: \_\_\_\_\_ (Print Name)

TABS ID: \_\_\_\_\_ MEDICAID #: \_\_\_\_\_ INITIALS: \_\_\_\_\_

MONTH/YEAR OF SERVICE DELIVERY: \_\_\_\_\_ PROVIDER SIGNATURE: \_\_\_\_\_ INITIALS: \_\_\_\_\_

CO-PROVIDER SIGNATURE: \_\_\_\_\_ INITIALS: \_\_\_\_\_

DESCRIPTION OF THE INDIVIDUALIZED SERVICE / ACTION PROVIDED based on the consumer's Residential Habitation Plan	Family Care Provider delivering the service or action <u>initials</u> 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.]																															
	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 the Family Care Residential Habitation Daily Checklist 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 \_\_\_\_\_





