



# Arkansas Department of Human Services

Division of Developmental Disabilities Services



## DDS COMMUNITY AND EMPLOYMENT SUPPORTS (CES) WAIVER MINIMUM CERTIFICATION STANDARDS

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## TABLE OF CONTENTS

### **I. SECTIONS APPLICABLE TO ALL WAIVER PROVIDERS, REGARDLESS OF WAIVER SERVICE BEING PROVIDED**

<b>SECTION</b>	<b>100</b>	<b>ORGANIZATIONAL/MANAGEMENT REQUIREMENTS AND SOLICITATION</b>
<b>SECTION</b>	<b>200</b>	<b>HIRING PROCEDURES AND PERSONNEL RECORD MAINTENANCE</b>
<b>SECTION</b>	<b>300</b>	<b>INCIDENT REPORTING</b>
<b>SECTION</b>	<b>400</b>	<b>BENEFICIARY AND LEGAL GUARDIAN RIGHTS</b>
<b>SECTION</b>	<b>500</b>	<b>SERVICE PROVISION</b>
	<b>501</b>	<b>Person Centered Service Plan</b>
	<b>502</b>	<b>Behavior Management Plan</b>
	<b>503</b>	<b>Restraints and Restrictive Intervention</b>
	<b>504</b>	<b>Medication Management Plan and Medication Logs</b>
	<b>505</b>	<b>Daily Service Activity Logs</b>
	<b>506</b>	<b>Beneficiary Service Records</b>
	<b>507</b>	<b>Refusal to Serve</b>
	<b>508</b>	<b>Transitioning Beneficiaries</b>

### **II. SPECIFIC WAIVER SERVICE SECTIONS**

<b>SECTION</b>	<b>600</b>	<b>PROVIDER QUALIFICATIONS: SUPPORTIVE LIVING</b>
<b>SECTION</b>	<b>700</b>	<b>PROVIDER QUALIFICATIONS: CARE COORDINATION</b>
<b>SECTION</b>	<b>800</b>	<b>PROVIDER QUALIFICATIONS: ADAPTIVE EQUIPMENT</b>
<b>SECTION</b>	<b>900</b>	<b>PROVIDER QUALIFICATIONS: ENVIRONMENTAL MODIFICATION</b>
<b>SECTION</b>	<b>1000</b>	<b>PROVIDER QUALIFICATIONS: SPECIALIZED MEDICAL SUPPLIES</b>
<b>SECTION</b>	<b>1100</b>	<b>PROVIDER QUALIFICATIONS: CONSULTATION</b>
<b>SECTION</b>	<b>1200</b>	<b>PROVIDER QUALIFICATIONS: RESPITE</b>
<b>SECTION</b>	<b>1300</b>	<b>PROVIDER QUALIFICATIONS: CRISIS INTERVENTION</b>
<b>SECTION</b>	<b>1400</b>	<b>PROVIDER QUALIFICATIONS: SUPPORTED EMPLOYMENT</b>
<b>SECTION</b>	<b>1500</b>	<b>PROVIDER QUALIFICATIONS: SUPPLEMENTAL SUPPORTS</b>
<b>SECTION</b>	<b>1600</b>	<b>PROVIDER QUALIFICATIONS: COMMUNITY LIVING/RESIDENTIAL SETTINGS</b>

## 100 ORGANIZATIONAL/MANAGEMENT REQUIREMENTS AND SOLICITATION

### 101. Organizational Requirements

1. Standards are not comprehensive: These DDS Community and Employment Supports Waiver Minimum Certification Standards (“**Certification Standards**”) establish those Provider policies, activities, and areas where DDS Quality Assurance will monitor Provider compliance.

However, these Certification Standards do not contain a comprehensive listing of all laws, statutes, guidelines, or other rules and regulations with which a Provider must comply. Depending on the services or programs a Provider chooses to offer and participate in, there may be other federal, state and local statutes, acts, and regulations with which a Provider must comply, including, but not limited to, the following:

- Health Insurance Portability and Accountability Act
- Freedom of Information Act
- Individuals with Disabilities Education Act
- American with Disabilities Act
- Federal Privacy Act
- Developmental Disabilities Assistance & Bill of Rights Act.

DDS Quality Assurance has the right to sanction Provider non-compliance with any laws, statutes, guidelines, or other regulations not found in the Certification Standards applicable to a Provider.

2. Provider Governing Documents Available for DDS Inspection: All governing documents, policies, procedures, or other equivalent operating documents of a Provider shall at all times be readily available for DDS inspection and review upon request.
3. Legal Existence and Good Standing: A Provider shall at all times be duly organized, validly existing and in good standing as a legal entity under the laws of the State of Arkansas, with the power and authority under the appropriate federal, state or local statutes to own and operate its business as presently conducted.
4. Provider Name and Control Changes:
  - a. *Name Changes*: Any change to the legal name of a Provider or the name under which a Provider conducts business in the State of Arkansas must be reported to DDS Quality Assurance within seven (7) days.

- b. *Control Changes*: Any change in the control of a Provider must be reported to DDS within seven (7) days. A “change in control” shall mean a change in the Executive Director or other titled position that is considered the highest position of authority for the Provider.
5. Governing Body Requirement: Each Provider’s governing body shall include at least one individual with developmental disabilities as an ex officio member (see Ark. Code Ann. § 20-48-705).
6. Provider Inability to Continue as Going Concern: If DDS receives information that would reasonably cause it to doubt a Provider’s ability to continue as a going concern, DDS Quality Assurance has the right to demand that the Provider present evidence that the Provider is still able to safely provide services in full compliance with these Certification Standards. Examples of actions or events that might trigger this concern include, but are not limited to, IRS liens, threats to revoke non-profit status, and the inability to pay employees, subcontractors, or others.

## **102. Management Requirements**

1. DDS QA Point of Contact: Each Provider must appoint a single member of management as the point of contact for all DDS Quality Assurance matters. This manager must have authority over all Provider employees, and would have sole responsibility for ensuring that DDS Quality Assurance’s requests, concerns, and inquiries are investigated and carried out.
2. Executive Director. Each Provider must appoint an Executive Director, or other titled officer position, that is vested with the authority and responsibility of overseeing all day-to-day Provider operations.

## **103. Organized Health Care Delivery System**

DDS has established an optional Organized Health Care Delivery System election as per 42 C.F.R. 447.10(b) for Providers. A Provider must deliver to DDS, in writing, a guarantee that the Provider will ensure the services of each subcontractor will comply with all Medicaid regulations and the Certification Standards. The Provider assumes all liability for subcontractor non-compliance. The Provider must deliver at least one HCBS Waiver service utilizing its own employees. DDS Quality Assurance’s annual review will determine compliance with the Certification Standards.

The Provider is required to have a duly executed subcontract in place that specifies the services to be rendered and assures that services will be completed by the subcontractor in a timely manner and be satisfactory to the beneficiary. The Provider is also responsible for the financial accountability of any subcontractor by ensuring that subcontractor services were delivered and proper documentation was submitted.

#### **104. Solicitation**

Solicitation of a beneficiary by a Provider is strictly prohibited, and a Provider that is found to be engaging in solicitation of a beneficiary will be subject to enforcement remedies. “Solicitation” means when a Provider (through its employees, owners, independent contractors, family members, or other agents) attempts to influence a beneficiary (or his or her family/guardian). Examples of prohibited solicitation include, but are not limited to, the following:

- 1.) Contacting a beneficiary or their family currently receiving services from another Provider to induce them to choose/switch Providers;
- 2.) Offering cash or gift incentives to a beneficiary or their family to induce them to choose/switch Providers;
- 3.) Offering free goods and/or services not available to other similarly stationed beneficiaries or their families to induce them to choose/switch Providers;
- 4.) Refusing to provide access to entitlement services for which the beneficiary is eligible if the beneficiary or their legal guardian selects another Provider for services;
- 5.) Making negative comments to a beneficiary or their family regarding the quality of services performed by another Provider;
- 6.) Promising to provide CES home and community based waiver services or other services in excess of those necessary to induce a beneficiary or their legal guardian to choose the Provider;
- 7.) Directly or indirectly giving a beneficiary or their family the false impression that the Provider is the only Provider that can perform the services desired by the beneficiary or their family; and
- 8.) Engaging in any activity that DDS Quality Assurance reasonably determines was intended to be “solicitation” as defined herein.

Marketing by a Provider is distinguishable from solicitation and is considered an allowable practice. Examples of acceptable marketing practices include, but are not limited to: (i) advertising using traditional media; (ii) distributing brochures and other informational materials regarding the services offered by a Provider; (iii) conducting tours of a Provider to interested beneficiaries; (iv) mentioning other services offered by the Provider in which a beneficiary might have an interest; and (v) hosting informational gatherings during which the services offered by a Provider are honestly described. All marketing must be factual and honestly presented, or a Provider could be subject to enforcement remedies.

## **200 HIRING PROCEDURES & PERSONNEL RECORD MAINTENANCE**

### **201. Hiring Procedures and Required Personnel Records**

#### **A. Prior to Employment**

The Provider must obtain and verify each of the following from an applicant prior to employment:

1. A completed job application that includes all the applicant's required current and up-to-date credentials.
2. A signed criminal conviction statement.
3. All required criminal background checks, as outlined in DDS Policy #1087 (A.C.A. § 20-38-101 et. seq. and §20-48-812, or any applicable successor statutes). DDS requires criminal background checks for the applicant, their spouse, and any children or other adult over the age of eighteen (18) if a beneficiary is to be permitted to stay overnight in an applicant's residence.
4. A signed declaration of truth of statement.
5. Completed reference checks.
6. A successfully passed drug screen.
7. If the applicant is applying for a position where transportation is required, a current and valid driver's license or a commercial driver's license (CDL), as appropriate.

#### **B. Post-Employment**

The Provider shall obtain and verify within thirty (30) days of an applicant's employment:

1. A completed Adult Maltreatment Central Registry check (see A.C.A. § 12-12-1716, or any successor statutes), or a second submission request if a response has not been received. An Adult Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of eighteen (18) that resides in a residence where a beneficiary is approved and permitted to stay overnight.
2. A completed Child Maltreatment Central Registry check (A.C.A. § 12-18-901 et. seq., or any successor statutes), or a second submission request if a response has not been received. A Child Maltreatment Central Registry check must be completed for the employee, their spouse, and any children or other adult over the age of eighteen (18) that resides in a residence where a beneficiary is approved and permitted to stay overnight.
3. A successfully passed criminal background check for the employee, their spouse, and any children or other adult over the age of eighteen (18) residing in a residence where a beneficiary is approved and permitted to stay overnight.

The Provider shall maintain the above documentation in the employee's personnel file for at least one (1) year following termination of employment.

C. Required Follow-up Checks

The child maltreatment registry checks required upon hiring in Section 201 must be repeated for each employee at least once every two (2) years. The criminal background and adult maltreatment registry checks required upon hiring in Section 201 must be repeated for each employee at least once every five (5) years. Failure to pass any required follow-up check at any time requires that the employee immediately cease unsupervised contact with beneficiaries.

D. New Information after Employment

If DDS or the Provider receives additional information after hiring that creates a reasonable belief that an employee has had a change in status in connection with one of the requirements in Section 201 (A) or (B) above (i.e. a license has been revoked/expired, an employee would no longer pass a criminal background and/or registry check, etc.), then the Provider must verify that the employee still meets all requirements for employment.

E. Exception

Any applicant who submits evidence of holding a current professional license is exempt from the criminal background, adult maltreatment and child maltreatment check requirements of this Section.

**202. Job Description Requirements**

The Provider shall create written job descriptions for each position offered that describe the duties, responsibilities, and qualifications for such staff position. In addition, the job description shall include the physical and educational qualifications and licenses/certifications required for each position. All employees that require a professional license must maintain current credentials.

**203. Sub-Contractors/Volunteer/Interns**

Each Provider must ensure that sub-contractors, students, interns, volunteers, and trainees or any other person who has regular, routine contact with beneficiaries are in compliance with all the requirements applicable to an "employee" that are contained in this Section 200. The classification of a worker as something other than an "employee" will not negate the responsibilities of the Provider under this Section 200.

## 300 INCIDENT REPORTING

### 301. Reportable Incidents

Providers must submit an incident report to DDS Quality Assurance using the automated form DHS 1910 via secure e-mail upon the occurrence of any one of the following events:

1. Death of beneficiary.
2. The use of any restrictive intervention, including seclusion, or physical, chemical, or mechanical restraint on a beneficiary.
3. Suspected maltreatment or abuse of a beneficiary.
4. Any injury to a beneficiary that:
  - Requires the attention of an Emergency Medical Technician, a paramedic, or physician
  - May cause death
  - May result in a substantial permanent impairment
  - Requires hospitalization
5. Threatened or attempted suicide by a beneficiary.
6. The arrest of a beneficiary, or commission of any crime by a beneficiary.
7. Any situation in which the whereabouts of a beneficiary is unknown for more than two (2) hours (i.e. elopement and/or wandering), or where services are interrupted for more than two (2) hours.
8. Any event where a staff member threatens a beneficiary.
9. Unexpected occurrences involving actual or risk of death or serious physical or psychological injury to a beneficiary.
10. Medication errors made by staff that cause or have the potential to cause serious injury or illness to a beneficiary, including, but not limited to, loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time, by the wrong route, and the administration of the wrong medication.
11. Any violation of a beneficiary's rights that jeopardizes the health, safety, or quality of life of the beneficiary.
12. Any incident involving property destruction by a beneficiary.



13. Vehicular accidents involving a beneficiary.
14. Biohazard incidents involving a beneficiary.
15. An arrest or conviction of a staff member providing direct care services.
16. Any use or possession of a non-prescribed medication or an illicit substance by a beneficiary.
17. Any other event that might have resulted in harm to a beneficiary or could have reasonably endangered the health, safety, or welfare of the beneficiary.

In addition to submitting incident reports for the reportable incidents described above to DDS Quality Assurance using the automated form DHS 1910 via secure e-mail, Providers are to also forward a copy of each incident report to the appropriate DDS Regional Area Group email address. This requirement also applies to any required follow-up incident reports described in Section 303. The DDS Regional Area Group email addresses are as follows:

[DHS.DDS.Central@arkansas.gov](mailto:DHS.DDS.Central@arkansas.gov)  
[DHS.DDS.NorthCentral@arkansas.gov](mailto:DHS.DDS.NorthCentral@arkansas.gov)  
[DHS.DDS.Northeast@arkansas.gov](mailto:DHS.DDS.Northeast@arkansas.gov)  
[DHS.DDS.Northwest@arkansas.gov](mailto:DHS.DDS.Northwest@arkansas.gov)  
[DHS.DDS.Southeast@arkansas.gov](mailto:DHS.DDS.Southeast@arkansas.gov)  
[DHS.DDS.Southwest@arkansas.gov](mailto:DHS.DDS.Southwest@arkansas.gov)

Providers should contact DDS Waiver Services with any questions regarding the appropriate DDS Regional Area Group email.

### **302. Reporting Timeframes**

#### **A. Immediate Reporting**

Providers must report the following incidents to the DDS Quality Assurance emergency number ((501) 765-9018) within one (1) hour of occurrence, regardless of hour:

- Suicide
- Death from adult abuse
- Death from child maltreatment
- Serious injury

#### **B. Incidents Involving Potential Publicity**

Incidents, regardless of category, that a Provider should reasonably know might be of interest to the public and/or media must be immediately reported to DDS Quality Assurance in central office if

during business hours, and to the DDS Quality Assurance emergency number ((501) 765-9018), if after business hours.

C. All Other Incident Reports

Except as otherwise provided above in subsection A and B, all reportable incidents must be reported to DDS Quality Assurance using the automated form DHS 1910 via secure e-mail no later than two (2) days following the incident. Any incident that occurs on a Friday is still considered timely if reported by the Monday immediately following.

**303. Required Incident Report Contents**

A. Initial Incident Report: Each initial incident report filed by a Provider must contain the following information:

1. Date of the incident
2. Detailed description of the accident/injury
3. Time of the incident
4. Location of incident
5. Persons involved in the incident
6. Other agencies contacted regarding incident, and the name of the individual in the agency that was contacted
7. Whether the guardian was notified of the incident and time of notification,
8. Whether the police were involved, and if so, a detailed description of their involvement
9. Any action taken by Provider or staff of Provider, both at the time of the incident and subsequent to the incident
10. Any expected follow-up
11. Name of person that prepared the report

When applicable, the Provider shall notify the parent or legal guardian of the beneficiary any time an incident report is submitted.

B. Follow-up Incident Reports: Information that is not available at the time of the initial incident report filing must be submitted in follow-up or final incident reports. These reports should be submitted in the same manner as soon as the additional information becomes available.

- The initial report should be resubmitted with the “follow-up” or “final” report areas checked and dated in the appropriate space on the incident report form.
- The current date should precede the new information in the text/narrative sections to differentiate follow-up information from the information originally submitted.

- A new form DHS-1910 should be submitted for follow-up and final reports only when there is insufficient space on the original form. Whenever a new form is submitted, the date of the original written report must be included for cross-referencing.

#### **304. Mandated Reporters**

The Arkansas Child Maltreatment Act and the Arkansas Adult Maltreatment Act deem all staff of Providers to be mandated reporters of any suspected adult or child abuse, neglect, exploitation, and maltreatment. Failure on the part of a Provider to properly report suspected abuse, neglect, exploitation, and maltreatment to the appropriate hotline is a violation of these Certification Standards.

## 400 BENEFICIARY AND LEGAL GUARDIAN RIGHTS

### 401. Beneficiary/Guardian Rights Policy

Each Provider must implement policies that enumerate in clear and understandable language each beneficiary's rights and the rights of the legal guardian of each beneficiary. The Provider must take reasonable steps to ensure beneficiaries and their legal guardians are: (i) informed of their rights; (ii) provided copies of the policies enumerating their rights prior to the initiation of services and at any other time upon request; and (iii) that the information is transmitted in a manner that the beneficiary and their legal guardian are able to read and understand.

### 402. Beneficiary Rights

Each Provider must, at a minimum, ensure the following beneficiary rights:

1. The right to be free from:
  - physical or psychological abuse or neglect
  - retaliation
  - coercion
  - humiliation
  - financial exploitation

The Provider must ensure that the application of corporal punishment to beneficiaries is prohibited. "Corporal punishment" refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.

2. The freedom to control their own financial resources.
3. The freedom to receive, purchase, possess, and use individual personal property. Any restriction on this right must be supported by an assessed need and justified in the beneficiary's person centered service plan ("**PCSP**").
4. The freedom to actively and meaningfully make decisions affecting their life and access pertinent information in a timely manner to facilitate such decision making.
  - If a beneficiary is age eighteen (18) or older, he/she is considered competent unless there is a court appointed legal guardian. Competent adults must always sign their own consents, releases, or other documentation requiring a signature.
  - A beneficiary who has a court appointed legal guardian retains all legal and civil rights except those which have been expressly limited by the court in the court

order, or which have been specifically granted to the legal guardian pursuant to the court order.

- Adult individuals who are legally competent shall have the right to decide whether their family will be involved in planning and implementing the PCSP.
5. The right to privacy. Any restriction on this right must be supported by an assessed need and justified in the PCSP.
  6. The right to choice of roommate when sharing a bedroom.
  7. The freedom to associate and communicate publicly or privately with any person or group of people of the beneficiary's choice at any time. Any restriction on this right must be supported by an assessed need and justified in the PCSP.
  8. The freedom to have visitors of their choosing at any time.
  9. The freedom of religion.
  10. The right to be free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment.
  11. The opportunity to seek employment and work in competitive, integrated settings to the same degree as those not receiving home and community based services through Medicaid.
  12. Freedom from being required to work without compensation.
    - There is a limited exception when residing in a Provider owned/controlled setting if the required work is related to the upkeep of the beneficiary's own living space, or the common living area and grounds that the beneficiary shares with others.
  13. The right to be treated with dignity and respect.
  14. The right to receive due process.
    - Providers must ensure beneficiaries have access to legal entities for appropriate and adequate representation, advocacy support services, and must adhere to research and ethics guidelines (45 CFR § 46.101 et. seq.).
    - Provider rules may not contain provisions that result in the unfair, arbitrary, or unreasonable treatment of a beneficiary.
  15. The right to contest and appeal Provider decisions affecting the beneficiary.

16. The right to request and receive an investigation in connection with an alleged infringement of a beneficiary's rights.
  - The Provider must maintain the documentation relating to all investigations of alleged beneficiary rights violations, and the actions taken to intervene in such situations. The Provider will ensure that the beneficiary has been notified of their right to appeal according to DDS Policy #1076.
17. The freedom to access their own records, including information regarding how their funds are accessed and utilized and what services were billed for on the beneficiary's behalf. Additionally, all beneficiaries and legal guardians must be informed of how to access the beneficiary's service records and the Provider must ensure that appropriate equipment is available for them to obtain such access.
  - Beneficiaries may not be prohibited from having access to their own service records, unless a specific state law indicates otherwise.
18. The right to live in a manner that optimizes, but does not regiment, beneficiary initiative, autonomy, and independence in making life choices, including but not limited to:
  - Choice of Provider
  - Service delivery
  - Release of information
  - Composition of the service delivery team
  - Involvement in research projects, if applicable
  - Daily activities
  - Physical environment
  - With whom to interact
19. Other legal and constitutional rights.

**403. Informing Beneficiary and/or Legal Guardian of their Rights**

The beneficiary and/or legal guardian shall be informed of their rights. The Provider shall maintain documentation in the beneficiary's service record showing that the following information has been provided to the beneficiary or legal guardian in writing:

1. All service options available to the beneficiary, including those not presently provided by the Provider and any available non-disability specific settings.
2. A copy of the appeal procedure for decisions made by the Provider.

3. A list of available external advocacy services.
4. A document informing the beneficiary or legal guardian of their right to appeal any service decision to DDS, along with a copy of DDS Policy #1076 regarding appeal procedures.
5. The care coordinator's name and contact information.
6. The name and phone number of the DDS Waiver Manager for the area.
7. A document describing any positive behavior programming practices (including, but not limited to, restraints) used by the Provider.

#### **404. Grievances and Appeals**

1. The Provider must institute and maintain policies that provide beneficiaries the right to file formal complaints/grievances and appeals.
2. The Provider must make complaint procedures and, if applicable, forms, readily available to all beneficiaries and their legal guardians. The complaint and appeals procedures must be in writing and understandable to the beneficiaries and legal guardians.
3. Complaint and appeal procedures shall be explained to personnel, beneficiaries, and legal guardians in a format that is easily understandable and meets their needs. This explanation may include, but is not limited to, a video, audiotape, a handbook, and interpreters.

#### **405. Financial Safeguards**

This Section applies if the Provider serves as a representative payee of a beneficiary, is involved in managing the funds of the beneficiary, receives benefits on behalf of the beneficiary, or temporarily safeguards funds or personal property for the beneficiary. Every supportive living Provider must comply with this Section.

##### **A. Financial Safeguards and Procedures**

The Provider must demonstrate, to the reasonable satisfaction of DDS, that there is a system in place to protect the financial interests of all beneficiaries. Provider personnel that have any involvement with beneficiary funds and the beneficiary or their legal guardian must receive a copy of the Provider's Financial Safeguards Policies and Procedures.

1. The Provider is responsible for ensuring that each beneficiary's funds are used solely for the benefit of the beneficiary.

2. The Provider must ensure that the beneficiary is able to receive the benefit of those items/services for which they are paying. By way of illustration, if a beneficiary is paying for internet, the beneficiary should have a device with which to access the internet; if the beneficiary pays for a cell phone plan, then the beneficiary should have a functioning cell phone.

B. Access to Financial Records

Beneficiaries and their legal guardians must have access to financial records concerning the beneficiary's account/funds at all times.

C. Financial Safeguards Policy and Procedures

The Provider must implement policies that define:

1. How beneficiaries will provide informed consent for the expenditure of their funds.
2. How beneficiaries will access their financial records.
3. How beneficiary accounts/funds will be segregated and maintained for accounting purposes.
4. The safeguards and procedures in place to ensure that beneficiary funds are used only for designated and appropriate purposes.
5. How interest will be credited to the accounts of the beneficiaries, if applicable.
6. A mechanism that provides evidence that beneficiary funds were expended in the manner authorized.

D. Consent Requirements

The Provider shall obtain consent from the beneficiary or their legal guardian prior to implementing the following:

1. Limiting the amount of funds a beneficiary may expend or invest in a specific instance.
2. Designating the amount a beneficiary may expend or invest for a specific purpose.
3. Establishing time frames where a beneficiary is required to or prohibited from expending or investing their funds.
4. Delegating responsibility for expending or investing a beneficiary's funds.



E. Additional Group Residential Setting Requirements

1. **Budget Requirement:** In group living residential settings, Providers must establish an individual budget for each beneficiary. At a minimum, each budget must include a detailed breakdown of monthly personal income (SSI, family contributions, job income, etc.) and monthly personal expenses (rent, utilities, food, clothing, extra-curricular activities etc.). Providers will be monitored to ensure that the budget is being implemented properly. It is the Provider's responsibility to revise the budget with the help of the beneficiary or legal guardian if the budget does not accurately reflect the actual income and/or expenditures of the beneficiary.
2. **Record Maintenance.** It is the responsibility of the Provider to maintain records and receipts that provide verifiable evidence that each beneficiary's funds are being used solely for the benefit of the beneficiary, and are not being used for the benefit of another beneficiary residing in the same setting. Examples of such documentation might include, but are not limited to, grocery receipts, bank statements, and paid invoices.
3. **Prohibition on Disproportionate Rental Payments:** A beneficiary's personal resources may not be taken into account when determining how much they are required to pay in rent. In group residential settings all beneficiaries must be charged the same amount in rent each month unless there is verifiable and reasonable justification.

406. Waiver Eligibility Disqualification

DDS will not authorize or continue waiver services under the following conditions:

1. When the health and safety of the beneficiary, the beneficiary's staff, or others cannot be assured.
2. When the beneficiary or legal guardian has refused or refuses to participate in the PCSP development or to permit implementation of the PCSP or any part thereof that is deemed necessary to assure health and safety.
3. When the beneficiary or legal guardian refuses to permit the on-site entry of:
  - The care coordinator or PCSP Developer to conduct scheduled/required visits,
  - Direct care staff to provide scheduled care, and
  - DHS or CMS officials acting in their role as oversight authority for compliance or audit purposes.
4. When the beneficiary applying for or receiving waiver services requires twenty-four (24) hour nursing care on a continuous basis as prescribed by a physician.

5. When the beneficiary is incarcerated or an inmate in a state or local correctional facility.
6. When the beneficiary is deemed ineligible based on a DDS Psychological Team assessment or reassessment finding that the beneficiary does not meet ICF/IID level of care.
7. When the beneficiary is ineligible based on not meeting or not complying with Medicaid eligibility requirements.

## 500 SERVICE PROVISION

### 501. Person Centered Service Plan

All CES waiver services are delivered pursuant to a person centered service plan (“**PCSP**”), which is based on the Independent Assessment and other needs assessments. The PCSP must have measurable goals and specific objectives, measure progress through data collection, and be developed, overseen, and updated through consultation with a PCSP team that must include the beneficiary.

#### A. Beneficiary Participation and Approval Required

The beneficiary (and, if applicable, their legal guardian) must be an active participant in the PCSP planning and revision process. The Provider must ensure that the PCSP development, planning, and update process is driven to the maximum extent possible by the beneficiary/legal guardian. Providers shall deliver services based on the choices of the beneficiary/legal guardian.

The written PCSP must be finalized and agreed to with the informed consent of the beneficiary/legal guardian in writing and signed by all individuals and Providers responsible for its implementation (see § 42 CFR 441.725 B).

#### B. Interim Service Plan

When a beneficiary accesses CES Waiver services for the first time, the beneficiary is issued an interim service plan (“**ISP**”) for up to sixty (60) days, until the PCSP can be developed and implemented. The ISP may include care coordination and supportive living for direct case supervision. DDS staff will track the expiration dates of ISPs and ensure that a PCSP is complete before the interim plan expires.

#### C. Initial PCSP Development Meeting

1. **Independent Assessment:** Every beneficiary must undergo an Independent Assessment performed by the designated DDS third party vendor prior to developing a PCSP for the beneficiary. The PCSP Developer must have the results of the Independent Assessment at the initial PCSP development meeting.
  - A beneficiary must receive an Independent Assessment through the designated DDS third party vendor at least once every three (3) years.
2. **Information Gathering:** Prior to the initial PCSP development meeting, in addition to the Independent Assessment, the PCSP Developer should secure for review as part of the meeting additional information which would be beneficial to the initial PCSP development process, including, but not necessarily limited to:
  - The results of any evaluations that are specific to the needs of the beneficiary

- The results of any psychological testing during eligibility determination
  - The results of any adaptive behavior assessments conducted to establish eligibility
3. **Scheduling and Attendees:** The PCSP Developer is responsible for scheduling, coordinating, and managing the PCSP development meeting, including inviting other participants, making sure that the location and the participants are acceptable to the beneficiary. Ideally this PCSP development team would consist of some combination of the beneficiary and/or their legal guardian, the beneficiary's parents or other family supports, the assigned DDS Waiver representative, professionals that conducted assessments/evaluation of beneficiary, and others who might provide support to the beneficiary.
- If the beneficiary or their legal guardian objects to the presence of any individual at the PCSP development meeting, then the individual is not permitted to attend the PCSP development meeting.

#### D. PCSP Requirements

Generally, the PCSP must reflect the services and supports that are important for the beneficiary to meet the needs identified in the Independent Assessment and other needs assessments, as well as what is important to the beneficiary with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the beneficiary, the written PCSP must:

1. Identify the setting in which the beneficiary chooses to reside.
2. Reflect the beneficiary's strengths, preferences, interests, and needs.
3. Reflect the beneficiary's clinical and support needs as identified through the Independent Assessment and other needs assessments.
4. Include individually identified goals and desired outcomes for the beneficiary.
5. Reflect the services and supports (both paid and unpaid) that will assist the beneficiary to achieve identified goals, and the providers of those services and supports, including natural supports.
6. Reflect the risk factors identified through the Independent Assessment and the measures in place to minimize them, including individualized back-up plans and strategies when needed.
7. Be understandable to the beneficiary, and the individuals important in supporting him or her. At a minimum, the PCSP must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
8. Identify the care coordination Provider and the individual care coordinator responsible for monitoring the PCSP.

9. Be finalized and agreed to, with the informed consent of the beneficiary in writing, and signed by all individuals and Providers responsible for the PCSP's implementation.
10. Be distributed to the beneficiary and other individuals/Providers involved in the development and implementation of the PCSP.
11. Prevent the provision of unnecessary or inappropriate services and supports.
12. Document any modifications to the PCSP that are contrary to the home and community based settings requirements (See Section 1607 for documentation requirements).

D. PCSP Reviews and Updates

1. **Annual Update:** The PCSP Developer must review and update the PCSP with the beneficiary (and anyone else the beneficiary desires to attend) at least annually. The annual PCSP update process should be very similar to the initial PCSP development process. The beneficiary selects the participants on the PCSP update team. The care coordinator secures the available and appropriate data, information, assessments, and evaluations and presents it to the PCSP Developer and PCSP update team. The PCSP Developer will then develop an updated PCSP that meets all the requirements in Section C above. The discussions and activities involved at each annual update meeting must be documented and maintained by the PCSP Developer in the beneficiary's service file. The writing should document the beneficiary's input and participation in all aspects of the review.
  2. Updates to a PCSP can occur more often than once a year, but additional updates require DDS prior authorization.
2. **Beneficiary Requested Updates:** A beneficiary must be allowed to request an update of their PCSP at any time.

**502. Behavior Management Plan**

A. When Behavior Management Plans Are Required

The care coordinator must develop and monitor implementation of an appropriate behavior management plan incorporating positive behavior support strategies when:

1. Three (3) or more distinct challenging behaviors occur in a three (3) month period; or<sup>1</sup>

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<sup>1</sup> "Challenging Behaviors" behaviors defined as problematic or maladaptive by others who observe the behaviors or by the person displaying the behaviors. They are actions that:

- Come into conflict with what is generally accepted in the individual's community,
- Often isolate the person from their community, or
- Are barriers to the person living or remaining in the community, and

2. Beneficiaries are prescribed psychotropic medications for behavior; or
3. Any other time the Provider, DDS Quality Assurance, or the DDS Psychological Team believes a beneficiary's behavior warrants intervention.

A Provider of direct care services must provide training to all staff who implement a behavior management plan. Training requirements include Introduction to Behavior Management, Abuse and Neglect and any other training as necessary.

#### B. Behavior Management Plans Generally

All behavior management plans must:

1. Prohibit behavior modification techniques that are punishing in nature, physically painful, emotionally frightening, depriving, or that put the beneficiary at medical risk.
2. Specify what behaviors, if any, require the use of restraints, the length of time to be used, person responsible for the authorization and the use of restraints (see Section 503 below), and the methods for monitoring the beneficiary and staff.
3. Prohibit the use of medications for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition, or for the purpose of chemical restraint.
4. Prohibit the use of mechanical restraints for the purpose of limiting or controlling challenging behavior. "Mechanical restraint" means any physical apparatus or equipment that cannot be easily removed by the beneficiary, restricts the free movement or normal functioning of beneficiary, or restricts normal access to a portion or portions of the beneficiary's body.

#### C. Behavior Management Plan Development

Behavior management plans must be written and monitored by a qualified professional who is, at a minimum, a Qualified Developmental Disabilities Professional ("QDDP"). The care coordination Provider (with input from the supportive living Provider) will develop a beneficiary's behavior management plan. All behavior management plans must:

1. Identify the behavior/s to be decreased.
2. Identify the behavior/s to be increased.

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- Vary in seriousness and intensity.

3. Identify what things should be provided or avoided in the beneficiary's environment on a daily basis to decrease the likelihood of the identified behavior/s.
4. Identify the methods that staff should use to manage behavior/s.
5. Identify the event/s that appear to trigger the behavior/s.
6. Identify what staff should do if the triggering event/s occur.
7. Identify what staff should do if the behavior/s to be increased or decreased occur.
8. Should involve the fewest interventions or strategies possible.
9. Be designed so that the rights of the individual are protected.
10. Preclude procedures that are punishing, physically painful, emotionally frightening, involve deprivation, or put the individual at medical risk.

D. Re-Evaluation of Behavior Management Plan

All behavior management plans must be re-evaluated at least quarterly. Behavior management plans must also be re-evaluated if:

1. Distinct behaviors occur three (3) or more times within a three (3) month period, which could all take place in one day; or
2. Any time that DDS determines that re-evaluation of the behavior management plan is appropriate under the circumstances.

Each Provider is responsible for maintaining written documentation sufficient to prove that any required re-evaluation was properly requested and conducted.

E. Data Collection for Behavior Management Plan

Each Provider delivering direct care services must collect data on the behavior management plan so that the effectiveness can be evaluated. A Provider delivering direct care services is required to:

1. Develop a simple, efficient, and manageable method of logging and collecting data regarding the implementation of the behavior management plan.
2. Data collection must include the frequency, length of time of each use, the duration of use over time and the impact of the use of interventions, if applicable.
3. Review the data regularly, and send the beneficiary to the behavior management plan developer (or other assigned QDDP) for re-evaluation if the strategies are not achieving the desired results.

## 503. Restraints & Restrictive Intervention

### A. Behavior Management Plan Required

A Provider is prohibited from using any restraints or restrictive interventions on a beneficiary unless the beneficiary has a developed and implemented behavior management plan which incorporates alternative strategies to avoid the use of restraints and restrictive interventions, and includes the use of positive behavior support strategies as an integral part of the behavior management plan (See Section 502 “Behavior Management Plans”). There is a limited exception to this requirement when the use of an emergency restraint is necessary (See Section 503 (E) “Emergency Restraint”)

### B. Definitions of Restraints and Interventions

1. **“Physical restraint”** or **“personal restraint”**: the application of physical force without the use of any device (manually holding all or part of the body), for the purpose of restraining the free movement of a beneficiary’s body. This does not include briefly holding, without undue force, a beneficiary in order to calm them, or holding a beneficiary’s hand to escort them safely from one area to another.
2. **“Physical Intervention”**: the use of a manual technique intended to interrupt or stop a behavior from occurring.
3. **“Restrictive intervention”**: procedures that restrict or limit a beneficiary’s freedom of movement, restricts access to their property, prevents them from doing something they want to do, requires them to do something they do not want to do, or removes something they own or have earned. The definition would include the use of “time-out,” in which a beneficiary is temporarily, for a specified period of time, removed from positive reinforcement or denied opportunity to obtain positive reinforcement for the purpose of providing the beneficiary with the opportunity to regain self-control. Under no circumstances may a beneficiary be physically prevented from leaving.
4. **“Mechanical restraint”**: any physical apparatus or equipment used to limit or control a challenging behavior. This would include any apparatus or equipment that cannot be easily removed by the beneficiary, restricts the beneficiary’s free movement or normal functioning, or restricts normal access to a portion or portions of the beneficiary’s body.
  - **Under no circumstances are mechanical restraints permitted to be used on a beneficiary.**
5. **“Chemical restraint”**: the use of medication for the sole purpose of preventing, modifying, or controlling challenging behavior that is not associated with a diagnosed co-occurring psychiatric condition.
  - **Under no circumstances are chemical restraints permitted to be used on a beneficiary.**



6. **“Seclusion”**: the involuntary confinement of a beneficiary alone in a room or an area from which the beneficiary is physically prevented from having contact with others or leaving.

- **Under no circumstances is seclusion permitted to be used on a beneficiary.**

C. Use of Restraints and Interventions

Permitted restraints and interventions may be used only when a challenging behavior exhibited by the beneficiary threatens the health or safety of the beneficiary or others. The use of restraints or interventions must be supported by a specific assessed need as justified in the beneficiary’s PCSP, and only performed as provided in the beneficiary’s behavior management plan.

1. **Required Prior Counseling**: Before a “time out,” an absence from a specific social activity, or a temporary loss of personal possession is implemented, the beneficiary must first be counseled about the consequences of the behavior and the choices they can make.
2. **Direct Observation**: A beneficiary must be continuously under direct visual and auditory observation by staff members during any use of restraints or interventions.
3. **Specialized Restraint and Intervention Training**: All personnel who are involved in the use of restraints or interventions must receive training on and be qualified to perform, implement, and monitor the particular restraint or intervention as applicable. Additionally, personnel should receive training in behavior management techniques, and abuse and neglect laws, rules, regulations and policies.
4. **Restraint and Intervention Identification**: The Provider is required to advise all staff, families, and beneficiaries on how to recognize and report the unauthorized use of a restraint or restrictive intervention.

D. Required Restraint and/or Intervention PCSP Information

Any PCSP and behavior management plan permitting the use of restraints or interventions must include the following information:

1. Identify the specific and individualized assessed need for the use of the restraint or intervention.
2. Document the positive interventions and supports used prior to any modifications to the PCSP that permits use of restraint or interventions.
3. Document the less intrusive methods of behavior modification that were attempted but did not work.

4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification to the PCSP that permitted the use of a restraint or intervention.
6. Include established time limits for periodic reviews to determine if the use of restraint or intervention is still necessary or can be terminated.
7. Include the informed consent of the beneficiary or legal guardian.
8. Include an assurance that the use of the restraint or intervention will cause no harm to the beneficiary.

E. Emergency Restraint

Personal restraints (use of staff member's body to prevent injury to the beneficiary or another person) are allowed in cases of emergency, even if a behavior management plan incorporating the use of restraints has not been developed and implemented. An "emergency" exists in the following situations:

1. The beneficiary has not responded to de-escalation or other positive behavior support strategies and the behavior continues to escalate.
2. The beneficiary is a danger to themselves or others.
3. The safety of the beneficiary and those nearby cannot be assured through positive behavior support strategies.

The care coordinator must request an interdisciplinary team meeting to revise the PCSP and implement a behavior management plan when there are more than three (3) emergency restraint incidents within a three (3) month period. It is an emergency restraint "incident" if each of the following occurred:

- A behavior was exhibited
- A restraint procedure was used
- The beneficiary was no longer thought to be dangerous
- The restraint procedure was discontinued

F. Reporting each Incident where Restraint or Intervention was Used

An incident report must be completed and submitted to DDS Quality Assurance in accordance with Section 300 herein no later than the end of the second business day following the date any restraint or restrictive intervention is administered. If the use of a restraint or restrictive intervention occurs more than three (3) times in any thirty (30) day period, permitted use of restraints and interventions must be

discussed by the PCSP development team, addressed in the PCSP, and implemented pursuant to an appropriate behavior management plan.

Any use of restraint or intervention, whether permitted or prohibited, also must be documented in the beneficiary's daily service log, maintained in their service record, and must include the following information:

1. The behavior initiating the use of restraint or intervention.
2. The length of time the restraint or intervention was administered.
3. The name of the personnel that authorized the use of the restraint or intervention.
4. The names of all individuals involved and outcomes of the use of the restraint or intervention.

#### **504. Medication Management Plan and Medication Logs**

The Provider delivering care coordination must develop a medication management plan for any beneficiary with prescribed medications. Providers delivering direct care services must maintain an accurate and up-to-date medication log for all beneficiaries to whom the Provider is responsible for administering medications, whether prescribed, pro re nata (“**PRN**”), or over-the-counter. A Provider must maintain written evidence of any beneficiary or legal guardian electing to administer all prescribed medications themselves.

##### **A. Medication Management Plan**

The care coordination Provider (with input from the supportive living Provider) must develop a medication management plan for all beneficiaries with prescribed medication/s. A medical prescription for medications, services, and level of care must be obtained annually. When medication is used to treat a specifically diagnosed mental illness, the prescribed medication must be managed by a psychiatrist who periodically provides information regarding the effectiveness of, and any side effects experienced from the medication. The prescription and management may be by a physician, if a psychiatrist is not available. Medications may NOT be used to modify behavior in the absence of a specifically diagnosed mental illness, or for the purpose of chemical restraint.

1. Each medication management plan must include:
  - How each medication will be administered (i.e. times, doses, delivery, etc.) and charted.
  - A list of potential side effects caused by any medication/s.
  - A description of the reason each medication has been prescribed and the related symptoms.
  - The beneficiary/legal guardian's consent to the administration of the medication/s.
  - How each medication must be administered and by whom, in order to comply with the Nurse Practice Act and the Consumer Directed Care Act. This would include a list which medications may be administered by which staff.

2. For all prescribed psychotropic medications due to behaviors, the care coordination Provider shall develop and implement a behavior management plan and update as necessary (See Section 502).
3. Providers are required to provide training to direct care staff which details the specifics of the beneficiary's medical management plan, including possible side effects.
4. Direct care staff members are required to be re-trained on the medication management plan and behavior management plan (if applicable) any time medications are updated.

B. Medication Logs

1. **Prescription Medications:** Providers delivering direct care services must maintain medications logs detailing the administration of prescribed medications to the beneficiary. The prescribed medication logs must be readily available for DDS review, and document the following for each administration of a prescribed medication:
  - Name and dosage of the medication administered.
  - Route the medication was administered.
  - Date and time the medication was administered (recorded at the time of medication administration).
  - Initials of the staff administering or assisting with the administration of the medication.
  - Any side effects or adverse reactions to the medication.
  - Any errors in administering the medication.
2. **PRN and Over-the-Counter Medications:** Providers delivering direct care services must also maintain logs concerning the administration of PRN and over-the-counter medications. The logs for the administration of prescription PRN and over-the-counter medications must document the following:
  - How often the medication is used.
  - Date and time each medication was administered (recorded at the time of medication administration).
  - The circumstances in which the medication is used.
  - The symptom for which the medication was used.
  - The effectiveness of the medication.

3. **Medication Administration Error Reporting/Charting:** Any medication administration errors occurring or discovered must be recorded in the medication log and immediately reported to a supervisor. “Medication administration errors” include, but are not limited to, the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, a missed dose, wrong dose, a dose being administered at the wrong time or by the wrong route, the administration of the wrong medication, and the discovery of an unlocked medication lock box that is supposed to be locked at all times.
  - An incident report must be filed with DDS Quality Assurance in accordance with Section 300 for any medication administration error that caused or had the potential to cause serious injury or illness to a beneficiary.
4. **Required Oversight Documentation:** Each Provider delivering direct care services must ensure that supervisory level staff (commonly titled Direct Care Supervisor) review on at least a monthly basis all beneficiary medication logs to determine if:
  - All medications were administered accurately as prescribed.
  - The medication is effectively addressing the reason for which it was prescribed.
  - Any side effects are noted, reported, and being managed appropriately.

#### **505. Daily Service Activity Logs**

Daily service activity logs must be maintained by all Providers delivering direct care services in order to provide specific information relating to the individually identified goals and desired outcomes for the beneficiary, so that the care coordinator, PCSP Developer, and PCSP development team can measure and record the progress on each of the beneficiary’s identified goals and desired outcomes. There is no required format for a daily service activity log; however, the daily service activity logs must document the following:

1. The name and sign-in/sign-out times for each direct care staff member.
2. The specific services furnished.
3. The date and actual beginning and ending time of day the services were performed.
4. Name(s) of the staff/person(s) providing the service(s).
5. The relationship of the services to the goals and objectives described in the beneficiary’s individualized PCSP.
6. Daily progress notes/narrative signed and dated by the staff delivering the service(s), describing each beneficiary’s progress or lack thereof with respect to each of his or her individualized goals and objectives. This would include any behavior management plan data required to be maintained pursuant to Section 502(E) above.

## **506. Beneficiary Service Records**

### **A. Required Service Record Documentation**

Each Provider delivering care coordination services or direct care services to a beneficiary must establish a service record for the beneficiary. At a minimum, the service record file must contain:

1. Independent Assessment
2. A copy of the PCSP
3. Behavior management plan with proper beneficiary/legal guardian approval, if applicable
4. Daily service activity logs
5. Care coordinator monthly contact reports
6. Completed forms as required by DDS, including, but not limited to, Form DHS-704, ACS/CES-703, and ACS/CES-102
7. Fully approved medication management plan and Medication logs, or signed election to self-administer medication (see Section 504), if applicable
8. Fully executed copy of lease, residency agreement, or other form of written agreement that provides protections that address eviction processes and appeals comparable to those provided under a landlord-tenant law
9. Any documentation providing additional individuals with access to a beneficiary's service record
10. Documentation required in Section 403
11. Guardianship Order, if applicable
12. Any specific documentation required by a particular CES Waiver service used by the beneficiary

### **B. Face Sheets**

A summary document ("Face sheet") must be maintained at the front of a beneficiary's service record file, which must document the following:

1. Full name of beneficiary
2. Address, county of residence, telephone number and email address, if applicable
3. Marital status, if applicable
4. Race and gender
5. Birth date
6. Social Security number
7. Medicaid Number
8. Legal status
9. Legal guardian's name and address and relationship, if applicable
10. Name, address, telephone number and relationship of person to contact in emergency
11. Health insurance benefits and policy number
12. Primary language
13. Admission date

14. Statement of primary/secondary disability
15. Physician's name, address, and telephone number
16. Current medications with dosage and frequency, if applicable
17. All known allergies or indicate none, if applicable

Face sheets must be updated as needed and after each PCSP update. Any update to a Face Sheet must be signed and dated by the person entering the update.

C. Beneficiary Records Maintenance & Storage Retention Requirements

1. **Confidentiality:** A Provider shall maintain complete service records/files and treat all information related to beneficiaries as confidential. Access to beneficiary service files must be limited to only those staff members who have a need to know the information contained in the records of the beneficiary. The only individuals that may access a beneficiary's files and records are:
  - The beneficiary
  - The legal guardian of the beneficiary, if applicable
  - Professional staff providing direct care or care coordination services to the beneficiary
  - Authorized Provider administrative staff
  - Any other individual authorized by the beneficiary or their legal guardian

Adult beneficiaries who are legally competent shall have the right to decide whether their family will be involved in planning and implementing their PCSP, and a signed release or document shall be present in their service record either granting permission for family involvement or declining family involvement.

2. **HIPAA Regulations:** Each Provider shall ensure that information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the Health Insurance Portability and Accountability Act ("**HIPAA**").
3. **Electronic and Paper Records/File Maintenance:** Electronic service records are acceptable. Paper and electronic service records must be uniformly organized and easily accessible. A list of the order of the service record information shall either be present in each beneficiary's service record or provided to DDS upon request. The documents in active service records should be organized in a systematic fashion. An indexing and filing system must be maintained for all service records.
4. **Storage Location:** The location of the files/service records, and the information contained therein, must be controlled from a central location.

5. **Direct Care Staff Access:** The Provider shall ensure all direct care and care coordination staff has adequate access to the beneficiary's file/service record including, current PCSP and other pertinent information necessary to ensure the beneficiary's health, welfare, and safety (i.e., name and telephone number of physician(s), emergency contact information, insurance information, etc.).
6. **Record/File Retention:** Each Provider must retain all files/services records for five (5) years from the date of service or until all audit questions or review issues, appeals hearings, investigations or administrative or judicial litigation to which the files/services records may relate are finally concluded, whichever period is later. Failure to furnish medical records upon request may result in sanctions being imposed. Federal legislation further requires that any accounting of private healthcare information ("PHI") or HIPAA policies or complaints must be retained for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.
7. **Access Sheets:** Access sheets shall be located in the front of the service record to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the service record, only those not listed will need to sign the access sheet with date, title, reason for reviewing, and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the service record is reviewed or any material is placed in the service record.

D. DDS Access to Beneficiary Files/Service Records

DDS shall have access to all beneficiary files/service records maintained by the Provider at any time upon demand.

**507. Refusal to Serve**

Providers shall not refuse services to any beneficiary unless the Provider cannot ensure the beneficiary's health, safety, or welfare. When a Provider is unable to serve a beneficiary, the Provider must notify the DDS Waiver Specialist within two (2) working days in order for choice to be offered to the beneficiary.

1. If a Provider is unable to ensure a beneficiary's health, safety, or welfare because qualified personnel are unavailable to deliver services to the beneficiary, the Provider should be able to demonstrate efforts to employ and retain qualified personnel and the results of those efforts. The documentation submitted by Provider should demonstrate:
  - Recruitment efforts
  - Retention efforts
  - Identification of any trends in personnel turnover



2. If the Provider is unable to ensure a beneficiary's health, safety, or welfare because adequate housing is not available, the Provider should develop and propose to the beneficiary alternative housing arrangements and locations within the beneficiary's resources. If the beneficiary is unable or unwilling to accept any of the proposed alternative housing arrangements or locations, the Provider shall document that the beneficiary has refused available resources and shall immediately notify the DDS Waiver Specialist.
3. The intent of this Section 507 is to prevent and prohibit Providers from implementing a selective admission policy based on the perceived "difficulty" of serving a beneficiary. Whether a Provider is refusing to serve based on legitimate beneficiary health, safety, or welfare concerns shall be determined in the sole discretion of DDS. DDS approval for refusal of services shall depend on the documented efforts made by the Provider to find housing and a determination of whether staffing can be provided by increasing the hourly rate of pay.

#### **508. Transitioning Beneficiary**

1. Corroboration and Responsibility: If it is necessary to transition a beneficiary to another Provider due to beneficiary choice, inability to serve, transition to an intermediate care facility, or any other reason, the current service Provider must fully cooperate with the care coordinator and any new service Provider in order to ensure a smooth transition process and the continuous delivery of services. The current service Provider shall remain responsible for the health, safety, and welfare of the beneficiary until the transition to the new service Provider is complete.
2. Turnover of Paperwork/Records: The current Provider must provide copies of the beneficiary's files, service records, data, and other paperwork without delay. If all copies of requested paperwork have not been provided to the care coordinator, DDS Waiver Specialist or the new Provider within thirty (30) days of the request, it is presumed to be unreasonable delay in violation of these Certification Standards.
3. Provider as Representative Payee: If the current Provider is serving as the transitioning beneficiary's representative payee (i.e. responsible for the beneficiary's finances), then within seven (7) days of the beneficiary's decision to transition the current Provider must submit the necessary paperwork to the Social Security Administration or any other necessary agency or financial institution. The current Provider is responsible for retaining written documentation evidencing that the necessary paperwork was submitted within the timeframe.
4. DDS Time-Extension: It is presumed any transition not completed within forty-five (45) calendar days from the date of the beneficiary's decision to transition is the result of undue delay by the current Provider. Notwithstanding the foregoing, a current Provider may submit written justification for any transition lasting longer than forty-five (45) calendar days to the beneficiary's DDS Waiver Specialist. DDS will determine if an extension is appropriate.

## **600 PROVIDER QUALIFICATIONS: SUPPORTIVE LIVING SERVICES**

### **601. Supportive Living Responsibilities**

1. Coordinating all supportive living staff that provide direct care to the beneficiary through the Provider;
2. Serving as a liaison between the beneficiary, parents, legal representatives, care coordinator and DDS representatives;
3. Coordinating schedules for both waiver and generic service categories;
4. Participating in planning and preparing the delivery of all supportive living services included in the initial PCSP and any annual or other PCSP update;
5. Assuring the integrity of all Medicaid waiver billing for all supportive living services delivered by Provider;
6. Arranging for the staffing of all alternative living settings;
7. Cooperating with the care coordinator and PCSP development team in developing a beneficiary's behavior management plan (see Section 502), if necessary, and then implementing, administering and collecting data relating to the behavior management plan;
8. Ensuring any necessary transportation is arranged for all supportive living services identified in the beneficiary's PCSP;
9. Collaborating with the care coordinator in a timely manner to obtain any Independent Assessment, comprehensive behavior and assessment reports, PCSP updates, and information and documents required for ICF/ID level of care and waiver Medicaid eligibility determination;
10. Reviewing the medication logs and daily service activity logs of the beneficiary to ensure the beneficiary is receiving appropriate services, medications and support in accordance with the PCSP and any medication management plan.

While the Provider may not staff a beneficiary on a 24/7 schedule, the Provider is responsible to ensure that sufficient staff is maintained to guarantee the health, safety, and welfare of each beneficiary, and to meet the established outcomes of the beneficiary as stated in their PCSP. Sufficiently trained staff shall be on duty at all times. Provisions shall be made for relief of supportive living staff during vacations, other relief periods and unplanned absences. Providers must have

backup plans in place to address contingencies if scheduled staff are unable, fail, or refuse to provide supportive living services.

## **602. Minimum Qualifications**

### Direct Care Staff

The Provider is responsible for the interviewing, hiring, firing, training, and scheduling of direct care staff providing supportive living services. Providers must ensure that all staff providing direct care services have one of the following:

- A high school diploma or GED;
- One (1) year of relevant, supervised work experience with a public health, human services or other community service agency; **OR**
- Two (2) years' verifiable successful experience working with individuals with developmental disabilities.

## **603. Medication Administration and Logs**

### 1. Medication Administration

Supportive living Providers must ensure that the beneficiary's medication management plan (See Section 504) incorporates measures which describe how direct care staff will administer or assist with the administration of medications. The Provider must ensure the medication management plan describes how the medication/s must be administered and by whom, in order to comply with the Nurse Practice Act and the Consumer Directed Care Act.

### 2. Medication Logs

The supportive living Provider has an on-going responsibility for monitoring beneficiary medication regimens. Providers must ensure that supportive living staff are at all times aware of the medications used by the beneficiary, and are knowledgeable of potential side effects. See Section 504(B) above for the specific medication log requirements.

## **604. Daily Service Activity Logs**

Providers must maintain daily service activity logs for each beneficiary. See Section 505 above for the specific requirements.

## 605. Training Requirements

1. First Aid Training: Within thirty (30) days of hiring, all supportive living staff, and any other staff of a supportive living Provider that may be required to provide emergency direct care services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.
  - The course must provide a certificate of completion that can be maintained in the supportive living staff's personnel file.
  - Any services provided by a supportive living staff person prior to receiving the above described First Aid Training can only be performed in a training role, under the supervision of another supportive living staff person that has already had the required First Aid Training.
  - Training Certification must be maintained and kept up to date throughout the time any supporting living staff is providing services.
2. Beneficiary Specific Training: Prior to beginning service delivery, supportive living staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supportive living services required pursuant to the beneficiary's PCSP, including, but not limited to:
  - general training on beneficiary's PCSP
  - behavior management techniques/programming;
  - medication administration and management;
  - setting-specific emergency and evacuation procedures
  - appropriate and productive community integration activities; and
  - training specific to certain medical needs.

Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supportive living staff member at all times. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended, or renewed.

3. Other Required Training: supportive living staff must receive appropriate training on the following topics at least once every two (2) calendar years:
  - HIPAA Policies and Procedures
  - Procedures for Incident Reporting

- Emergency and Evacuation Procedures
- Introduction to Behavior Management
- Arkansas Guardianship statutes
- Arkansas Abuse of Adult statutes
- Arkansas Child Maltreatment Act
- Nurse Practice Act
- Appeals Procedure for Individuals Served by the Program
- Beneficiary Financial Safeguards
- Community Integration Training
- Procedures for Preventing and Reporting Maltreatment of Children and Adults
- Other topics where circumstances dictate that supportive living staff should receive training to ensure the health, safety, and welfare of the beneficiary.

Documentation evidencing that training on the topics has been completed must be maintained in the personnel file of the supportive living staff member at all times.

4. DDS QA Mandated Training: DDS Quality Assurance has the ability to require a supportive living provider to conduct/administer specified training to an individual, a group, or all supportive living staff working for the Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each supportive living service staff member at all times.

## **700 PROVIDER QUALIFICATIONS: CARE COORDINATION SERVICES**

Starting in October 2017, care coordination will begin to be phased out as a CES Waiver service. In October 2017, DHS and DDS will implement a Provider-led Managed care model for case management/care coordination where an independent third party vendor will conduct an Independent Assessment of each beneficiary for a tier determination, as well as a needs and risks assessment. Upon receiving the results of the Independent Assessment, the beneficiary will be attributed to and enrolled in a Provider-led Share Savings Entity (“**PASSE**”). Once a beneficiary is enrolled in a PASSE, care coordination services will no longer be available to the beneficiary as a CES Waiver service. Care coordination services will be performed by the PASSE under a separate home and community based services waiver.

### **701. Conflict Free Case Management**

A Provider delivering care coordination services to a beneficiary must follow the federal conflict free case management rules.

### **702. Care Coordinator Minimum Qualifications**

A. Care coordination Providers must require each care coordinator to meet the following minimum qualification criteria:

1. Be a Registered Nurse (R.N.), a physician, or have a bachelor’s degree in a social science or health-related field; **OR**
2. Have at least one (1) year of experience working with developmentally or intellectually disabled clients or behavioral health clients;

B. Person Centered Service Plan Developer

Providers must require any supportive living staff responsible for the development of a beneficiary’s PCSP (“**PSCP Developer**”) to meet one of the following minimum qualification criteria:

1. A Bachelor’s degree in a human services related field.
2. Two (2) or more years college credit in the field of human services, and two (2) years’ experience working with individuals with developmental disabilities.
3. Two (2) or more years’ experience working with individuals with developmental disabilities, and two (2) additional years of mentoring/training under a case manager.

4. Four (4) or more years' experience working as a case manager in a related field

### **703. Care Coordination Responsibilities**

Care coordination services include responsibility for guidance and support in all life activities including the following:

1. Coordinating and arranging for the provision of all CES Waiver services and other state plan services;
2. Identifying and accessing needed medical, social, educational, and other publicly funded sources (regardless of funding source);
3. Identifying and accessing informal community supports needed by beneficiaries and their families;
4. Providing the beneficiary with guidance and support for their generic needs;
5. Coordinating and monitoring the implementation of all services identified on the beneficiary's PCSP, whether such services are home and community based waiver services, state plan services or generic services;
6. Coordinating with and monitoring the beneficiary's supportive living and other direct care Providers to ensure quality of care and service delivery;
7. Monitoring the beneficiary to assure their health, safety, and welfare;
8. Facilitating crisis intervention for the beneficiary;
9. Securing, scheduling, and/or conducting the beneficiary's Independent Assessment, other appropriate needs assessments, evaluations, and referrals for resources when required/necessary;
10. Providing the beneficiary with assistance in connection with continuing waiver Medicaid eligibility and obtaining ICF/IID level of care eligibility determinations;
11. Monitoring the beneficiary to ensure that the services and supports meet the needs, goals, and objectives identified in PCSP, with regard to the beneficiary's preferences for the delivery of such services and supports, and ensuring that the PCSP is revised/updated if the current services and supports are ineffective or the beneficiary's preferences change;
12. Assuring submission of timely and comprehensive behavior and assessment reports, updated PCSP, revisions to PCSP, and information and documents required for ICF/IID level of care and waiver Medicaid eligibility determinations;

13. Informing the beneficiary of their rights, providing support and training to each beneficiary so that they may identify attempts at exploitation, and arranging for a beneficiary to have access to advocacy services when requested;
14. Upon receipt of DDS approvals and denials, ensuring that a copy of each approval and denial is provided to the beneficiary or their legal representative;
15. Providing support and assistance with appeals when a beneficiary receives an adverse decision and desires to appeal the decision;
16. Assisting the beneficiary with transitioning between service settings or service Providers;
17. Assisting the beneficiary with selecting a primary care physician (“**PCP**”) or providing a referral to a person centered medical home (“**PCMH**”), if necessary.

#### **704. PCSP Development Responsibilities**

Provider is responsible for the development of a beneficiary’s person centered service plan (“**PCSP**”) and ensuring the delivery of all supportive living services including the following activities:

11. Developing/updating the beneficiary’s PCSP in cooperation with the beneficiary or the beneficiary’s legal representative, and any other individual/s the beneficiary/legal representative wishes to have participate on the PCSP development team.
  - The PCSP developer is responsible for scheduling, coordinating, and managing the PCSP development/update meetings, including inviting other participants, and making sure that the location and the participants are acceptable to the beneficiary.
  - If the beneficiary objects to the presence of any individual at a PCSP development/update meeting, then that individual is not permitted to attend the PCSP development meeting.;
12. Scheduling, coordinating, and managing the PCSP annual update and any other necessary updates, including inviting other participants, making sure that the location and the participants are acceptable to the beneficiary;

#### **705. Caseload Limit**

No individual providing care coordination services is permitted to have more than fifty (50) beneficiaries on their case load at any one time.



## 706. Mandatory Beneficiary Contact

1. Monthly Contact: The care coordinator must stay in regular contact with each beneficiary, and must have face-to-face contact with each beneficiary at least once a month. After the initial contact, these monthly contacts can be made via video-conferencing. During each contact the care coordinator should discuss issues related to services and supports the beneficiary is supposed to be receiving pursuant to their PCSP, including, but not limited to:

- Whether or not the beneficiary feels that their needs are being met.
- Whether the beneficiary is satisfied with their Provider/s.
- Inform the beneficiary they are always free to change Providers.
- Whether there are any beneficiary health, safety, or welfare concerns.

The care coordinator must report any service gap of thirty (30) consecutive days to the DDS Wavier Specialist assigned to the beneficiary. The report must include the reason for the gap and identify remedial action to be taken. A copy of the report must be maintained in the beneficiary's service record file.

2. 24 Hour Availability: The Provider must ensure that care coordination services are available to a beneficiary twenty-four (24) hours a day through a hotline or web-based application.
3. Crisis Contact: If the beneficiary is seen in an emergency room, urgent care clinic, or is admitted to an acute inpatient psychiatric facility, the care coordinator must follow up with the beneficiary within seven (7) days of discharge from the facility. The visit is to ensure that all discharge instructions are being followed and any follow-up appointments have been scheduled.
4. Required Documentation: The care coordinator must document all monthly contacts with the beneficiary and maintain the documentation in the beneficiary's service record file. Documentation shall include:
  - a) The date and time of the contact/meeting
  - b) The location of the contact/meeting
  - c) The individuals present during the contact/meeting
  - d) A summary of the contact/meeting
  - e) Any requests by the beneficiary for change in services or new services
  - f) The documentation reciting the above required details must be signed by the care coordinator and the beneficiary.

## **707 Request to Change Provider**

A beneficiary or their legal guardian may initiate a request to change Providers by contacting (written or verbally) their care coordinator. If a request to change Provider is received by the care coordinator, the care coordinator shall forward the request to the DDS Waiver Specialist within two (2) working days of its receipt. The current service Provider will remain responsible for delivery of services until such time as the transition to the new Provider is complete. When there is a request to change Providers, the care coordinator is responsible for overseeing and facilitating the transition process, including, but not limited to the following:

- Facilitating a transitional meeting with any direct care service Provider/s;
- Collecting the beneficiary's service record file and other available information for the transitional meeting;
- Determining the effective date for transfer of service responsibilities; and
- Ensuring that the beneficiary does not suffer a lapse in services due to the change in Providers.

## **708. Abeyance**

### **A. Abeyance Generally**

A beneficiary's waiver status is in "abeyance" when there is a cessation of implementation of the beneficiary's PCSP while the beneficiary is temporarily placed in a licensed or certified facility for the purposes of behavior, physical, or health treatment or stabilization. The beneficiary will remain eligible for and enrolled in the CES Waiver without harm during an abeyance period. The care coordinator is responsible for requesting for a beneficiary's status to be placed into abeyance by contacting the DDS Waiver Specialist. The request for abeyance must be in writing and include all supporting evidence. Approval of a request for abeyance is made by DDS, and will be made for an initial period of up to ninety (90) days.

A beneficiary "living" in a public institution is not eligible for Medicaid or CES Waiver services, and an abeyance request cannot be granted in such circumstances. Public institutions include county jails, state and federal penitentiaries, juvenile detention centers, and other correctional or holding facilities.

### **B. Abeyance Extensions**

The abeyance period may be extended in ninety (90) day increments for up to one (1) year total. Each request for continuance must be submitted in writing and supported by evidence of treatment status or progress. Requests for continuance must be made prior to the expiration of the abeyance period.

### **C. Required Contact**

A care coordinator must continue monitoring contact with a beneficiary whose case is in abeyance. The care coordinator must have a minimum of one (1) face-to-face visit or contact each month and

report the status to the applicable DDS Waiver Specialist. After the initial contact, these monthly contacts can be made via video-conferencing. Monthly status reports are required to be submitted to the DDS Waiver Specialist as long as the person is in abeyance.

#### **709. Adaptive Equipment and Environmental Modifications**

The care coordinator is responsible for handling adaptive equipment and environmental modification purchases for a beneficiary. Equipment may be purchased only when unable to be purchased through any other source, and all equipment must be solely for the use of the beneficiary.

1. **Mandatory Consultation Threshold:** When the purchase price of any single piece of equipment or single modification is \$500 or greater, the care coordinator must seek an appropriate professional consultation to ensure that the equipment or modification to be purchased will meet the intended need of the beneficiary.
2. **Mandatory Bidding Threshold:** When any equipment or modification will be in excess of \$1,000, the care coordinator must attempt to obtain at least three bids. The bids must be awarded to the lowest bid that meets the required quality level.
3. **Final Inspection:** Final inspection for the quality of the equipment or modification and compliance with specifications and local codes is the responsibility of the care coordinator. Payment to the supplier/contractor will be withheld until DDS receives a customer satisfaction statement signed by the care coordinator certifying that (i) the equipment/modification authorized has been delivered/completed, (ii) the beneficiary's property has been left in satisfactory condition, and (iii) any incidental damages have been repaired.
4. **Required Documentation:** The care coordinator must maintain in the beneficiary's service file written documentation evidencing that any required professional consultation and bidding was conducted as part of any adaptive equipment or environmental modification purchase. If a care coordinator is unable to secure three (3) bids, then the care coordinator must be able to document their efforts of the unsuccessful steps taken to secure the required three (3) bids.

#### **7010. Training Requirements**

1. **First Aid Training:** Within thirty (30) days of hiring, all care coordination staff, and any other staff of a care coordination provider that may be required to provide emergency services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

- The course must provide a certificate of completion that can be maintained in each care coordinator's personnel file.
  - Training Certification must be maintained and kept up to date throughout the time any care coordinator is providing care coordination services.
2. Other Required Training: care coordinators must receive appropriate training on the following topics at least once every two (2) calendar years:
- HIPAA Policies and Procedures
  - Procedures for Incident Reporting
  - Emergency and Evacuation Procedures
  - Introduction to Behavior Management
  - Arkansas Guardianship statutes
  - Arkansas Abuse of Adult statutes
  - Arkansas Child Maltreatment Act
  - Nurse Practice Act
  - Appeals Procedure for Individuals Served by the Program
  - Community Integration Training.
  - Procedures for Preventing and Reporting Maltreatment of Children and Adults
  - Other topics where circumstances dictate that care coordinators should receive training to ensure the health, safety, and welfare of the beneficiary served.

Documentation evidencing that training on the topics listed above was completed must be maintained in the personnel file of each care coordinator at all times.

3. DDS QA Mandated Training: DDS Quality Assurance has the ability to require a care coordination Provider to conduct/administer specified training to an individual care coordinator, a group of care coordinators, or all care coordinators working for the Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each care coordinator at all times.

## **800 PROVIDER QUALIFICATIONS: ADAPTIVE EQUIPMENT (ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS)**

### **801. Adaptive Equipment Units**

1. The Provider must deliver professional, ongoing assistance when needed to evaluate and adjust any equipment delivered and/or to instruct the beneficiary or the beneficiary's caregiver in the use of equipment furnished.
2. The Provider must have the prior approval of DDS for any adaptive equipment items purchased and delivered. Equipment may only be covered if not available to the beneficiary from any other source.

### **802. Liability**

1. The Provider must assume liability for equipment, supplies, warranties and must install, maintain, and/or replace any defective parts or items specified in those warranties. Replacement items or parts for adaptive equipment are not reimbursable as rental equipment.
2. The Provider must, in collaboration with the care coordinator, ascertain and recoup any third-party resource(s) available to the consumer prior to billing DDS or its designee. DDS or its designee will then pay any unpaid balance up to the lesser of the Provider's billed charge or the maximum allowable reimbursement.

### **803. Records of Adaptive Equipment**

The Provider must submit the price for equipment and/or supplies to be purchased or rented within five (5) business days of the care coordinator's request for a bid. The Provider must maintain a record for each order. The documentation shall consist of:

1. The date the order was received and the name of the care coordinator placing the order.
2. The price quoted for the equipment and/or supplies.
3. The date the quote was submitted to the care coordinator.

The Provider must maintain a record for each beneficiary. The record must document the delivery, installation of the equipment purchased or rented, any education and/or instructions for the use of the equipment and/or supplies provided to the beneficiary, and must include documentation of delivery of item(s) to the beneficiary. The documentation shall consist of:

1. The beneficiary's signature, the signature of the beneficiary's caregiver or electronic verification of delivery.
2. The date on which the equipment and/or supplies were delivered.

## **900 PROVIDER QUALIFICATIONS: ENVIRONMENTAL MODIFICATION SERVICES**

### **901. Required Credentials**

Providers must be appropriately licensed and bonded in the State of Arkansas, as required, or have other appropriate credentials to perform jobs requiring specialized skills, including but not limited to:

- Electrical
- HVAC
- Plumbing
- General Contracting

All services must be completed as directed by the beneficiary's PCSP, and in accordance with all applicable state or local building codes. Environmental modifications must be made within the existing square footage of the residence.

### **902. Documentation**

Providers must obtain and maintain the following documentation:

1. The written consent of the property owner to modify the property. When appropriate, the Provider must ensure that the owner understands that the property will be left in the modified state after the beneficiary vacates the premises.
2. An original photo of the site where modifications will be done.
3. A to-scale sketch plan of the proposed modification project.
4. Any necessary inspections, inspection reports, and permits required by federal, state and local laws either prior to commencing work or upon completion of each job to verify that the repair, modification or installation was completed. The Provider must obtain these inspections, inspection reports, and permits prior to billing for the completed job.
5. A signed and dated authorization from the beneficiary's care coordinator, or care coordinator's designee, for each job order prior to commencing work.
6. Written evidence that the Provider has informed the beneficiary and DDS or its designee of any health and/or safety risks expected during the job. The Provider is required to assist the beneficiary and care coordinator to coordinate dates and times of work to assure minimal risk of hazard to the beneficiary.

7. Obtain the beneficiary's or legal guardian's signature and the care coordinator's signature at job completion in order to certify that the work authorized has been completed, the beneficiary's property has been left in satisfactory condition, and any incidental damages have been repaired.
8. Maintain an itemized record of all expenses including materials and labor associated with the job order for a minimum of five (5) years.

**903. Warranty**

The Provider must furnish a warranty covering workmanship and materials with the final invoice submitted to DDS or the care coordinator. DDS will not pay any invoice that is not accompanied by a warranty.

**904. Payor of Last Resort**

Environmental modifications may only be purchased if not available to the beneficiary from any other source. The Provider must, in collaboration with the care coordinator, ascertain and recoup any third-party resource(s) available to the consumer prior to billing DDS or its designee. When environmental modifications are included as a Medicaid state plan service, a denial by utilization review will be required prior to approval for Waiver funding by DDS.

## **1000 PROVIDER QUALIFICATIONS: SPECIALIZED MEDICAL SUPPLIES**

### **1001. Specialized Medical Supplies**

A physician must order or document the need for all specialized medical supplies. Specialized medical supplies include:

- Items necessary for life support or to address physical conditions along with, ancillary supplies and equipment necessary for the proper functioning of such items;
- Such other durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to address participant functional limitations.
- Necessary medical items not available under the Medicaid State Plan.

Additional items are covered as a waiver service when they are considered essential for home and community care. Items covered include:

- Nutritional supplements
- Non-prescription medications (alternative medicines not FDA approved are excluded from coverage)
- Prescription drugs minus the cost of drugs covered by Medicare Part D when extended benefits available under the State plan are exhausted.

### **1002. Provider Requirements**

1. The Provider must assure professional, ongoing assistance when needed to evaluate and adjust medical supplies delivered and/or to instruct the beneficiary or the beneficiary's caregiver in the use of the medical supplies furnished.
2. The Provider must have the prior approval of DDS for any medical supply items purchased and delivered.
3. The Provider must assume liability for medical supplies and must replace any defective items.
4. The Provider must, in collaboration with the care coordinator, ascertain and recoup any third-party resource(s) available to the beneficiary prior to billing DDS or its designee.



DDS or its designee will then pay any unpaid balance up to the lesser of the Provider's billed charge or the maximum allowable reimbursement.

**1003. Documentation**

The Provider must submit the price for medical supplies to be purchased or rented within five (5) business days of the care coordinator's request. The Provider must maintain a record for each order. The documentation shall consist of:

1. The date the order was received and the name of the care coordinator placing the order.
2. The price quoted for the item.
3. The date the quote was submitted to the care coordinator.

The Provider must maintain a record for each beneficiary. The record must document the delivery, installation of the item(s) purchased or rented, any education and/or instructions for the use of the equipment and/or supplies provided to the beneficiary, and must include documentation of delivery of item(s) to the beneficiary. The documentation must include:

- The beneficiary's signature, the signature of the beneficiary's caregiver or electronic verification of delivery.
- The date on which the equipment and/or supplies were delivered.

## **1100 PROVIDER QUALIFICATIONS: CONSULTATION SERVICES**

### **1101. Licensed Professionals**

Providers will be responsible for maintaining the necessary information to document staff qualifications. Selected staff or contract individuals may not provide training unless they possess the specific qualifications required. Consultant services are indirect in nature.

### **1102. Qualifications**

Providers must ensure that any individual providing consultation has current credentials which correspond to the specific area of consultation they provide. Providers must be able to provide evidence that the following professionals providing consultation services through the Provider hold a current license or certification by the following licensing or certification board or organization:

1. Psychologists: hold a current license from the Arkansas Psychology Board as a Psychologist
2. Psychological examiners: hold a current license from the Arkansas Psychology Board as a Psychological Examiner
3. Mastered social workers: hold a current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board
4. Professional counselors: hold a current license as a counselor by the Arkansas Board of Examiners in Counseling
5. Speech pathologists: hold a current license in Speech Therapy by the Arkansas Board of Audiology and Speech Language Pathology
6. Occupational therapists: hold a current license in Occupational Therapy by the Arkansas State Medical Board.
7. Physical Therapy: hold a current license in Physical Therapy by the Arkansas Board of Physical Therapy.
8. Registered Nurses: hold a current license as a Registered Nurse by the Arkansas Board of Nursing.
9. Certified parent educators: meet the qualifications of a Qualified Developmental Disabilities Professional as defined in 42 C.F.R. Subsection 483.430(a)

10. Certified communication and environmental control adaptive equipment/aids providers: be currently enrolled as a provider of Durable Medical Equipment with the Arkansas Medicaid Program.
11. Qualified Developmental Disabilities Professional: meet the qualifications defined in 42 C.F.R. Subsection 483.430(a)
12. Dietician: hold a degree in nutrition.
13. Behavior Support Specialist: certified through our Center of Excellence University of Arkansas Partners for Inclusive Communities
14. Rehabilitation counselors: hold a masters degree in Rehabilitation Counseling.
15. Recreational Therapist: hold a degree in Recreational Therapy.
16. Behavior Analyst: hold a certification by the Behavior Analyst Certification Board as defined in A.C.A. § 23-99-418.

### **1103 Documentation**

The Provider must maintain a record of every consultation service provided for each beneficiary. The documentation shall consist of:

1. The date the consult was provided and the name of the care coordinator requesting the consult.
2. The consultation service provided.
3. A detailed narrative regarding the content of each consulting session.

## **1200 PROVIDER QUALIFICATIONS: RESPITE SERVICES**

### **1201. Minimum Qualifications**

Providers must ensure that each staff member providing respite services has one of the following:

- A GED or high school diploma;
- One (1) year of relevant, supervised work experience with a public health, human services or other community service agency; **OR**
- Two (2) years' verifiable successful experience working with individuals with developmental disabilities

### **1202. Approved Settings**

Respite may be provided in the following locations:

1. Beneficiary's home or private place of residence
2. Private residence of a Respite care Provider
3. Foster home
4. Medicaid certified intermediate care facility
5. Group home
6. Licensed respite facility
7. Licensed or accredited residential mental health facility
8. Licensed day care facility or other lawful child care setting

When respite is provided in a Medicaid certified ICF/ID, licensed respite facility, or licensed residential mental health facility, the time of the stay may not exceed thirty (30) consecutive days.

### **1203. Physical Environment**

Providers must ensure the physical environments of facilities where respite services are provided are compatible with the services being provided and the needs of beneficiary and staff. The Provider shall provide an accessible and safe environment and be in compliance with U.S.C. § 12101 *et. seq.* "American with Disabilities Act of 1990." The environment must be appropriate and cannot jeopardize the health, safety, or welfare of beneficiaries.

## **1204. Training Requirements**

### **A. First Aid Training**

Within thirty (30) days of hiring, all respite staff, and any other employees that may be required to provide respite services to a beneficiary (such as on-call emergency staff or management), shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.

- The course must provide a certificate of completion that can be maintained in the staff's personnel file.
- Any services provided by respite staff prior to receiving the above described First Aid Training can only be performed in a trainee role, under the supervision of another staff person that has already received the required First Aid Training.
- Training Certification must be maintained and kept up to date throughout the time any respite service Provider is providing services.

### **B. Beneficiary Specific Training**

Prior to beginning service delivery, respite staff must receive the amount of individualized, beneficiary-specific training required to demonstrate the skills and techniques necessary to implement the individual Person-Centered Service Plan for each individual for whom they are responsible. Training must focus on skills and competencies directed toward the beneficiaries developmental, behavioral, and health needs. Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of beneficiaries. The Provider must ensure that the necessary amount of beneficiary-specific training was completed and written documentation evidencing training must be maintained in the staff member's personnel file at all times.

### **C. Other Required Training**

Respite Services staff must receive appropriate training on the following topics at least once every two (2) calendar years:

- HIPAA Policies and Procedures
- Procedures for Incident Reporting
- Emergency and Evacuation Procedures
- Introduction to Behavior Management
- Arkansas Guardianship statutes
- Arkansas Abuse of Adult statutes

- Arkansas Child Maltreatment Act
- Nurse Practice Act
- Appeals Procedure for Individuals Served by the Program
- Community Integration Training.
- Procedures for Preventing and Reporting Maltreatment of Children and Adults
- Other topics where circumstances dictate that respite staff should receive training to ensure the health, safety, and welfare of the beneficiary served.

Documentation evidencing that training on the topics listed above was completed must be maintained in the staff member's personnel file at all times.

D. DDS QA Mandated Training

DDS Quality Assurance has the ability to require a respite services Provider to conduct/administer specified training to an individual, group, or all staff working for the Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each Respite Services staff member at all times.

## **1300 PROVIDER QUALIFICATIONS: CRISIS INTERVENTION SERVICES**

### **1301. Provider Assurances**

Providers must be able to initiate services on-site within two (2) hours of request. Documentation for crisis intervention services must, at a minimum, include the time of the request, the name of the individual making the request, the time of arrival on-site, a summary of the intervention services provided, any recommendations for changes in the behavior plan or recommendations in change in medications, the time intervention services were discontinued, the signature of the Provider, and the signature of the care coordinator/caregiver as appropriate.

### **1302. Qualifications**

Each professional staff member providing crisis intervention services must hold a current license/certification through their respective state Board of licensing/certification as follows:

1. Psychologists: hold a current license from the Arkansas Psychology Board as a Psychologist
2. Psychological examiners: hold a current license from the Arkansas Psychology Board as a Psychological Examiner
3. Mastered social workers: hold a current license as an LMSW or ACSW by the Arkansas Social Work Licensing Board
4. Professional counselors: hold a current license as a counselor by the Arkansas Board of Examiners in Counseling
5. Qualified Developmental Disabilities Professional: meet the qualifications defined in 42 C.F.R. Subsection 483.430(a)
6. Behavior Support Specialist: certified through our Center of Excellence University of Arkansas Partners for Inclusive Communities

### **1303. Incident Reporting**

Providers must adhere to Incident Report Standards found in Section 300 of this manual.

## 1400 PROVIDER QUALIFICATIONS: SUPPORTED EMPLOYMENT

Supported Employment is a tailored array of services that offers ongoing support to beneficiaries to assist in their goal of working in competitive integrated work settings for at least minimum wage. It is intended for beneficiaries for whom competitive employment has not traditionally occurred, and who need ongoing supports to maintain their employment.

### 1401. Supported Employment Supports

#### A. Discovery/Career Planning Services

1. **Services Included:** discovery/career planning services consist of the Provider gathering information about the beneficiary's interests, strengths, skills, the types of supports that are most effective, and the types of environments and activities where the beneficiary is at his or her best. The following activities may be a component of Discovery/Career planning services:

- Review of the beneficiary's work history, interest, and skills
- Job exploration
- Job shadowing
- Informational interviewing including mock interviews
- Job and task analysis activities
- Situational assessments to assess the beneficiary's interest in and aptitude for a particular type of job
- Employment preparation (i.e. resume development)
- Benefits counseling
- Business plan development for self-employment
- Volunteerism

2. **Individual Career Profile:** discovery/career planning services should result in the development of an Individual Career Profile for the beneficiary, which includes specific recommendations regarding the beneficiary's employment support needs, preferences, abilities, and characteristic of optimal work environment.

3. **Required Documentation:** the Provider must produce and maintain the following documents in the beneficiary's service record to demonstrate compliance in the delivery of discovery/career planning services:

- Completed Individual Career Profile



- Record of progress notes/narratives detailing information gathering process and steps taken by Provider in developing the beneficiary's Individual Career Profile

## B. Employment Path Services

1. **Services Included:** employment path service activities develop and teach soft skills utilized in integrated employment, which include, but are not limited to, following directions, attending to tasks, problem solving skills and strategies, mobility training, effective and appropriate communication, both verbal and nonverbal, and time management. The beneficiary's employment path service activities must be designed to support employment goals, and can replace non-work services.
2. **Part of PCSP:** beneficiaries receiving employment path services must have goals related to employment in integrated community settings in their person centered service plan ("**PCSP**").
3. **Limits:** employment path services are time-limited and require prior authorization for the first twelve (12) months. One re-authorization of up to an additional twelve (12) months is possible, but only if the beneficiary is also receiving job development services, which indicates the beneficiary is actively seeking employment.
4. **Required Documentation:** the Provider must produce and maintain the following documents in the beneficiary's service record to demonstrate compliance with delivery of employment path services:
  - Beneficiary's PCSP
  - Detailed progress notes/narratives
  - An Arkansas Rehabilitation Services ("**ARS**") referral letter for beneficiary

## C. Employment Supports Services

Employment supports services consist of two (2) primary components: (i) job development and (ii) job coaching.

1. **Job Development:** individualized services that are specific in nature to obtaining a certain employment opportunity. The initial outcome of job development services is a Job Development Plan to be incorporated with the Individual Career Profile no later than thirty (30) days after job development services commence. The Job Development Plan must at a minimum specify:
  - The short and long term employment goals, target wages, task hours, and special conditions that apply to the worksite for that beneficiary.

- The jobs that will be developed and/or description of customized tasks that will be negotiated with potential employers.
  - An initial list of employer contacts and plan for how many employers will be contacted each week.
  - The conditions for use of on-site job coaching.
2. **Job Coaching:** on-site activities that may be provided to a beneficiary once employment is obtained. Activities provided under job coaching services may include, but are not limited to, the following:
- Complete job duty and task analysis.
  - Assist the beneficiary in learning to do the job by the least intrusive method.
  - Develop compensatory strategies, if needed, to cue beneficiary to complete job.
  - Analyze work environment during initial training/learning of the job.
  - Make determinations regarding modifications or assistive technology.

This service may also be utilized when the beneficiary chooses self-employment. Activities such as assisting the beneficiary to identify potential business opportunities, assisting in the development of business plan, as well as other activities in developing and launching a business. Medicaid Waiver funds may not be used to defray expenses associated with starting or operating a self-employment business such as capital expenses, advertising, hiring and training of employees.

3. **Required Documentation:** the Provider must produce and maintain the following documents in the beneficiary's service record to demonstrate compliance and delivery of employment support services:
- a) *Job development*
    - 1. Job Development Plan
    - 2. Beneficiary's remuneration statement
  - b) *Job coaching:* the Provider must develop a fading Job Coaching Plan to be completed within twelve (12) months. Additional authorizations of Employment Supports Job Coaching with no additional fading gains will require additional documentation of level of need for service.

#### D. Employment Supports Extended Services

1. **Services Included:** The expected outcome of employment supports extended services is sustained paid employment at or above minimum wages with associated benefits and

opportunities for advancement in a job that meets the beneficiary's personal and career planning goals. This service allows for the continued monitoring of the employment outcome through maintenance of regular contact with the beneficiary and employer. Activities allowed under this service must include, but are not limited to, a minimum of one (1) contact per quarter with the employer.

2. **Required Documentation:** The Provider must maintain the following documents to demonstrate compliance and delivery of this service:

- ARS letter of closure.
- Beneficiary's remuneration statement.
- Beneficiary's work schedule, if available.
- Detailed documentation of the topics and issues discussed during all Beneficiary and employer meetings/contacts.

#### **1402. Minimum Qualifications**

Providers must be currently licensed as a vendor by ARS as a Community Rehabilitation Program. Supported employment services must be provided by certified job coaches under the Provider's ARS license. Continued certification is a qualification requirement for the period the Provider is certified to provide supported employment services. Providers must maintain documentation of certification on file.

#### **1403. Required Training**

1. **First Aid Training:** Within thirty (30) days of hiring, all supported employment staff shall be required to attend and complete a certified first aid course administered by certified instructors of the course. The course must include instruction on common first aid topics and techniques, including, but not limited to, how to perform CPR, how to apply the Heimlich maneuver, how to stop/slow bleeding, etc.
  - The course must provide a certificate of completion that can be maintained in the supported employment staff's personnel file.
  - Any services provided by a supported employment staff person prior to receiving the above described First Aid Training can only be performed in a training role, under the supervision of another supported employment staff person that has already completed the required First Aid Training.
  - Training Certification must be maintained and kept up to date throughout the time any supported employment staff person is providing supported employment services.

2. Beneficiary Specific Training: Prior to beginning service delivery, supported employment staff must receive the amount of individualized, beneficiary-specific training that is necessary to be able to effectively and safely provide the supported employment services required pursuant to the beneficiary's PCSP, Individual Career Profile, and/or Job Development Plan, including, but not limited to:
  - general training on beneficiary's PCSP
  - behavior management techniques/programming;
  - medication administration and management;
  - setting-specific emergency and evacuation procedures
  - appropriate and productive community integration activities; and
  - training specific to certain medical needs.

Documentation evidencing that the necessary types and amount of beneficiary-specific training were completed must be maintained in the personnel file of the supported employment staff member at all times. This type of individualized, beneficiary-specific training shall be required each time a beneficiary's PCSP is updated, amended, or renewed.

3. Other Required Training: supported employment staff must receive appropriate training on the following topics at least once every two (2) calendar years:
  - HIPAA Policies and Procedures
  - Procedures for Incident Reporting
  - Emergency and Evacuation Procedures
  - Identifying Unsafe Environmental Factors
  - Introduction to Behavior Management
  - Arkansas Guardianship statutes
  - Arkansas Abuse of Adult statutes
  - Arkansas Child Maltreatment Act
  - Nurse Practice Act
  - Procedures for Preventing and Reporting Maltreatment of Children and Adults
  - Other topics where circumstances dictate that supported employment staff should receive training to ensure the health, safety, and welfare of the beneficiary served.

Documentation evidencing that training on the topics listed above was completed must be maintained in the personnel file of the supported employment staff member at all times.

4. DDS QA Mandated Training: DDS Quality Assurance has the ability to require a supported employment provider to conduct/administer specified training to an individual, a group, or all supported employment staff working for Provider, if DDS Quality Assurance reasonably deems such training necessary for the health, welfare, and/or safety of any one or more beneficiaries. Documentation evidencing that the DDS QA mandated training was completed must be maintained in the personnel file of each supported employment service staff member at all times.

## **1500 PROVIDER QUALIFICATIONS: SUPPLEMENTAL SUPPORT SERVICES**

### **1501. Qualifications**

The Provider must require all staff that coordinate the expenditure of supplemental support funds to have at least one of the following qualifications/experience:

1. A Bachelor's degree in a human services field.
2. Two (2) years college credit and two (2) years' experience working with persons with developmental disabilities.
3. Two (2) years of verified experience working with persons with a developmental disability and have been mentored by a case manager for two (2) additional years.
4. Four (4) years of experience as a case manager in a related field.

### **1502. Supplemental Supports**

#### **A. Permissible Supplemental Supports**

1. Ancillary supports such as non-recurring set-up expenses for beneficiaries in the event of a disaster, crisis, emergency or life threatening situation. Allowable expenses are those necessary to enable a beneficiary to establish a basic household and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; and (e) moving expenses. This service is furnished only to the extent that it is reasonable and necessary as determined through the beneficiary's PCSP development process, clearly identified in the beneficiary's PCSP, and the beneficiary is unable to meet such expenses, or when the services cannot be obtained from other sources.
2. Drug and alcohol screening in accordance with the beneficiary's treatment plan.
3. Activity fees such as dues at a YMCA, Weight Watchers, etc., used for behavior reinforcement or sensory stimulation. Fees are approved for the beneficiary only and for such time as to abate the life threatening condition. The services must be prescribed and monitored by medical professionals.

B. Exclusions

Supplemental Support may not include payment for room and board, monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. Supplemental Support may not be used to pay for furnishing living arrangements that are owned or leased by a Waiver provider where the provision of these items and services are inherent to the service they are already providing. Diversional or recreational items such as televisions, cable TV access or VCR's are not allowable.

**1503. Provider of Last Resort**

Supplemental support services can be accessed only as a last resort. A lack of other available resources must be documented and proven prior to a beneficiary receiving supplemental support services.

## **1600 PROVIDER QUALIFICATIONS: COMMUNITY LIVING-RESIDENTIAL SETTINGS**

### **1601. Accessibility Requirements**

Provider owned/leased/rented residential settings must be fully accessible by the beneficiary, compatible with the services being provided to the beneficiary, and compatible with the needs of each beneficiary and their staff, as provided in the beneficiary's PCSP. Each Provider owned/leased/rented residential facility must be in compliance with U.S.C. § 12101 et. seq. "American with Disabilities Act of 1990," and 29 U.S.C. §§ 706 (8), 794 – 794(b) "Disability Rights of 1964."

### **1602. Regulatory Approvals**

All water, food service, and sewage disposal systems must have the required approval of local, state, and federal regulatory agencies, as applicable.

### **1603. Safe and Comfortable Environment**

The Provider must ensure that each Provider owned/leased/rented residential settings provide a safe and comfortable environment tailored towards the needs of the beneficiary/ies, as provided for in their PCSP/s. This shall include, but not be limited to:

1. All Provider owned/leased/rented residential settings must meet all local and state building codes, regulations and laws.
2. The temperature must be maintained within a normal comfort range for the climate.
3. The interior and exterior of the residential setting must be maintained in a sanitary and repaired condition.
4. The residential setting must be free of offensive odors.
5. The residential setting must be maintained free of infestations of insects and rodents.
6. All materials, equipment, and supplies must be stored and maintained in a safe condition. Cleaning fluids and detergents must be stored in original containers with labels describing contents.

### **1604. Emergency and Evacuation Procedures**

The Provider must establish emergency procedures which include detailed actions to be taken in the event of emergency and promote safety. Details of emergency plans and procedures must be in written form, and shall be available and communicated to all members of the staff and other supervisory personnel.

A. There shall be written emergency procedures for:

1. Fires.
2. Natural disasters.
3. Utility failures
4. Medical emergencies
5. Safety during violent or other threatening situations

Additionally, the emergency procedures must satisfy the requirements of applicable authorities, and contain practices appropriate for the locale (example: nuclear evacuations for those living near a nuclear plant).

B. The Provider shall maintain an emergency alarm system for each type of drill (fire and tornado).

C. Beneficiaries, as appropriate, must be educated and trained about emergency and evacuation procedures.

D. Evacuation procedures must address:

1. When evacuation is appropriate.
2. Complete evacuation from the physical facility.
3. The safety of evacuees.
4. Accounting for all persons involved.
5. Temporary shelter, when applicable.
6. Identification of essential services.
7. Continuation of essential services.
8. Emergency phone numbers.
9. Notification of the appropriate emergency authorities.

E. In group living environments, evacuation routes must be posted in conspicuous places.

### **1605. Safety Equipment**

Providers must maintain the following items in each setting in which beneficiaries reside:

1. Functioning smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers
2. Functioning fire extinguishers
3. Functioning flash light
4. Functioning hot water heater
5. Emergency contact numbers (i.e. law enforcement, poison control etc.)
6. First-Aid kit



**1606. Required Independence and Integration**

Beneficiaries must be safe and secure in their homes and communities, taking into account their informed and expressed choices. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.

- A. Providers must take reasonable steps to ensure that beneficiaries are safe and secure in their homes and communities, taking into account the beneficiary's informed and expressed choices.
- B. Participant risk and safety considerations shall be identified and potential interventions considered that promote independence and safety with the informed involvement of the beneficiary.
- C. Beneficiaries shall be allowed free use of all space within the group living setting/alternative living site with due regard for privacy, personal possessions of other residents/staff, and reasonable house rules.
- D. Settings must be able to provide beneficiaries access to community resources and be located in a safe and accessible location. Beneficiaries must have access to the community in which they are being served. The site shall assure adequate/normal interaction with the community as a group AND as an individual.
  - This can be achieved through transportation or through local community resources.
- E. The living and dining areas must be provided with normalized furnishings for the usual functions of daily living and social activities.
- F. The kitchen shall have equipment, utensils, and supplies to properly store, prepare, and serve three (3) meals a day. Beneficiaries must have access to food at any time. Any modification to this requirement must be based on an assessed need and documented in the beneficiary's PCSP.
- G. Bedroom areas are required to meet the following:
  - 1. Shall be arranged so that privacy is assured for beneficiaries. Sole access to these rooms cannot be through a bathroom or other bedrooms. Bedrooms must be equipped with a functioning lock with only appropriate staff having keys.
  - 2. Beneficiaries must have a choice of roommate when shared by one or more individuals. The Provider must actively address the need to designate space for privacy and individual beneficiary interests.
  - 3. Physical arrangements shall be compatible with the physical needs of the individuals.

4. Each beneficiary shall have an individual bed. Each bed must have a clean, adequate, comfortable mattress.
    - a. Beds are of suitable dimensions to accommodate the beneficiary who is using it. Mattresses must be waterproof as necessary.
    - b. Each beneficiary must have a suitable pillow, pillowcase, sheets, blanket, and spread.
    - c. Bedding must be appropriate to the season and beneficiary's personal preferences. Bed linens must be replaced with clean linens at least weekly.
  5. Bedroom furnishings for beneficiaries shall include shelf space, individual chest or dresser space, and a mirror. An enclosed closet space adequate for the belongings of each beneficiary must be provided.
  6. Eighty (80) square feet per beneficiary in multi-sleeping rooms; one hundred (100) square feet in single bedrooms.
- H. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- I. Bathroom areas are required to meet the following criteria:
1. Sole access may not be through another beneficiary's bedroom. Commodes, tubs, and showers used by beneficiaries must provide for individual privacy.
  2. A minimum of one commode and sink is provided for every four (4) beneficiaries. Lavatories and commode fixtures are designed and installed in an accessible manner so that they are usable by the beneficiaries living in the residential setting.
  3. A minimum of one tub or shower is provided for every eight (8) beneficiaries.
  4. Must be well ventilated by natural or mechanical methods.

#### **1607. Home and Community Based Services (HCBS) Settings Requirements**

All providers must meet the Home and Community-Based Services (HCBS) Settings regulations as established by CMS. The federal regulation for the rule is 42 CFR 441.301(c) (4)-(5). All Provider owned/leased/rented residential settings must have the following characteristics:

1. Be chosen by the beneficiary from among setting options including non-disability specific settings (as well as an independent setting), and an option for a private unit in a residential setting.
  - a. Choice must be identified/included in the beneficiary's PCSP.
  - b. Choice must be based on the beneficiary's needs, preferences and, for residential settings, resources available for room and board.
2. Ensure a beneficiary's rights of privacy, dignity and respect and freedom from coercion and restraint.
3. Must optimize, but not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
4. Facilitate beneficiary choice regarding services and supports and who provides them.
5. The setting must be integrated in and support full access to the greater community by the beneficiary, including the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as beneficiaries not receiving CES Waiver services.
6. The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.
7. Each beneficiary has privacy in their sleeping or living unit, which must include the following:
  - i. Units have entrance doors lockable by the beneficiary, with only appropriate staff having keys to doors.
  - ii. Beneficiaries sharing units have a choice of roommates in that setting.
  - iii. Beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
8. Beneficiaries have the freedom and support to control their own schedules and activities and have access to food at any time.
9. Beneficiaries are able to have visitors of their choosing at any time.
10. The setting is physically accessible to the beneficiary.

11. Any modification of the additional conditions specified in items 6 through 10 above must be supported by a specific assessed need and justified in the beneficiary's PCSP. The following requirements must be documented in the beneficiary's PCSP:
  - i. Identify a specific and individualized assessed need.
  - ii. Document the positive interventions and supports used prior to any modifications to the PCSP.
  - iii. Document less intrusive methods of meeting the need that have been tried but did not work.
  - iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
  - v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
  - vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
  - vii. Include the informed consent of the beneficiary.
  - viii. Include an assurance that interventions and supports will cause no harm to the beneficiary.