Partnership for Hope Waiver Manual

Rev. 10/6/2011

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The purpose of the Partnership for Hope waiver is to prevent or delay of institutional services for individuals who require minimal services in order to continue living in the community. The waiver will offer prevention services to stabilize individuals primarily living with family members who provide significant support, but are not able to meet all of the individual's needs.

Goals

To increase access to waiver services for children and adults at the local level in participating counties.

Objectives

The objectives of the waiver are:

1) to increase the capacity of the State to meet the needs of individuals at risk of institutionalization who require minimal supports to continue living in integrated community settings;
2) to partner with local County Boards through Intergovernmental Agreements in the administration and funding of waiver services; and
3) to implement preventive services in a timely manner in order that eligible participants may continue living in the community with their families.

Organizational Structure

The waiver is administered by the Division of Developmental Disabilities through an interagency agreement with the Single State Medicaid Agency, Department of Social Services, Mo HealthNet Division. Through intergovernmental agreements specific waiver administrative tasks are delegated to

the boards of the 84 participating counties with oversight by the Division of Developmental Disabilities, which is the operating agency.

Service Delivery Methods

While traditional service delivery methods will be used, participant-directed services will be an option. The Division of DD's method of service delivery for other 1915(c) waivers it administers will be used including eligibility determination, provider contracting, prior authorization, claim submission, claim payment, and quality assurance oversight.

Eligibility

Participants in this program must be eligible for Medicaid, be determined to have mental retardation and/or a developmental disability, and require ICF/MR level of care. Persons do not require residential services and typically are living in the community with family members. The individual is at risk of needing ICF/MR institutional services if unable to access waiver services to subsidize care and support provided by the community and family. The estimated cost of waiver services and supports necessary to support the person must not exceed $12,000 annually.

Prioritization of Need Categories

The Partnership for Hope waiver does not use the Division's Prioritization of Need form. The Partnership for Hope waiver has developed a county based Prioritization of Need system. It is divided into Crisis and Priority. If a person falls into the 'Crisis' category they will be served first. If multiple people fall into the 'Crisis' category, the person who has been waiting the longest will be served first. If no one is in the 'Crisis' category then the person waiting the longest under the 'Priority' category will be served first. Each county will determine who falls into what category. The Regional Offices will only pass the form through to request a Partnership for Hope waiver slot from Central Office.

Crisis

- Health and Safety conditions pose a serious risk of immediate harm or death to the individual or others;
- Loss of Primary Caregiver support or change in caregiver's status to the extent the caregiver can't meet needs of the individual; or
- Abuse, Neglect or Exploitation of the individual.
    - Each bullet point in Crisis Category has equal weight.

Priority

- Individual's circumstances or conditions necessitate substantial accommodation that cannot be reasonably provided by the individual's primary caregiver;
- Person has exhausted both educational and VR benefits or not eligible for VR benefits and have a need for pre-employment or employment services;

- Individual has been receiving supports from local funding for 3 months or more and services are still needed and the service can be covered by the waiver. Refinancing; or
- Person living in a non-Medicaid funded RCF chooses to transition to the community and determined capable of residing in a less restrictive environment with access to the PFH.
    - Each bullet point in Priority Category has equal weight.

Exceptions Process

If an individual has needs in excess of the cost limit of $12,000, to ensure health and welfare of the individual an exception may be granted for additional services above the individual cost cap.

If an individual has a change in condition or circumstances that exceed the cost limit of $12,000, to ensure health and welfare of the individual an exception may be granted for additional services above the individual cost cap.

The Service Coordinator will revise the Service Plan to add information regarding the increased need. The service plan will go to UR for approval or denial. If plan is approved with no alternatives then the County Board Director will request the exception. Exceptions are granted by Division Director or designee.

- One-time expense or during crisis or transition not to exceed $10,000
- Individual cost cap for on-going up to $3,000 annually.

Section A: Staff Education Definitions

Developmental Disability Professional (DDP)

Degreed Professional Management (*relevant experience may be substituted for degree*). Responsibilities include:

- Staff training and supervision;
- Quality enhancement monitoring;
- Direct plan implementation for individuals as needed;
- Monitoring implementation of outcomes;
- Establishing information collection systems;
- Writing monthly reviews; and
- Oversight/coordination of all the person's programs and services being received.
- Coordinating the development of the individual service plan (scheduling, facilitation and summary document).

Developmental Disability Professional is required for the following services: Community Employment, Day Service and Personal Assistance.

Direct Care Staff

Must be 18 years of age and have the following:

- A high school diploma or its equivalent*;
- Current certification in a competency based CPR/First Aid Course;
- Training in preventing, detecting, and reporting of abuse and neglect prior to providing direct care;
- Training in the implementation of (*each individual's)* service plan (within one month of employment) (*effective 09/01/07)* and training in a positive behavior support curriculum approved by the Division of DD (within 3 month of employment);
- Additionally, staff administering medication supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070;
- One year experience working with people with developmental disabilities, or in lieu of experience, must successfully complete training in the Missouri Quality Outcomes approved by the Division of DD regional office (For Day Service Only).

  **Exemptions to H.S. diploma/GED requirement:*
  † *Staff without diplomas or GEDs employed by the same provider prior to 7/1/96 will be "grandfathered".*
  † *Staff without diplomas or GEDs may be employed for up to one year, while the person works to attain the requirement. The provider must document the staff's enrollment in school or GED courses.*
  † *After 7/1/96, staff without diplomas or GEDs who already have five or more years of direct working experience may be employed with the approval of the regional office. The provider is responsible for maintaining documentation of the five years of experience and of regional center agreement in the employee's file.*

Section B: Documentation Requirements

Adequate Documentation

All services provided must be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3.030, Section (2) (A) defines —adequate documentation and —adequate medical records as follows: Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered, with the exception of in-home services such as personal care, home health, etc.

Documentation

Implementation of services must be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive residential habilitation or individualized support

living and at least quarterly for individuals who live in their natural home. As per 13 CSR 70 – 3.030, the provider is required to document the provision of Division of DD Waiver services by maintaining:

- First name, and last name, and either middle initial or date of birth of the service recipient.
- An accurate, complete, and legible description of each service(s) provided. This information may be included in daily activity records that describe various covered activities (services) in which the person participated.
- Name, title, and signature of the Missouri Medicaid enrolled provider delivering the service. This may be included in attendance or census records documenting days of service, signed by the provider or designated staff; records indicating which staff provided each unit of service; and documentation of qualifications of staff to provide the service.
- Identify referring entity, when applicable.
- The date of service (month/day/year). This can be included in attendance or census records.
- Start and stop time must be included in the documentation for MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering the service, such as personal assistant. This would apply to DD Waiver services. (e.g., 4:00 – 4:30 p.m.).
- Services that do not have a time factor in completing service does not require a start and stop time, but would need to have related documentation to verify the service was provided (e.g., invoices for equipment, trip reports for transportation, etc).
- The setting in which service was rendered.
- Service plan, evaluation(s), test(s), findings, results, and prescription(s) as necessary.
- Service delivery as identified in the individual's service plan.
- Recipient's progress toward the goals stated in the treatment plan (progress notes). Sources of documentation include progress notes by direct care staff regarding situations (whether good or bad) that arise affecting the individual; and monthly provider summaries noting progress on individual's goals and objectives in their service plan, and overall status of the individual.
- For applicable programs, include invoices, trip tickets/reports, activity log sheets, employee records (excluding health records), and staff training records.
- Applicable documentation should be contained and available in the entirety of the medical record.

All providers must follow the above documentation requirements unless otherwise noted under specific Division of DD Waiver services in Sections 13.18 through 13.37. Any additional requirements for a specific service are also included in these sections.

Section C: Self Directed Supports

Self -Directed Supports (SDS) is an option for service delivery for individuals with developmental disabilities who wish to exercise more choice, control and authority over their supports. SDS is founded on the principles of Self-Determination. Under this option the individual or their designated representative has employment and budget authority.

- Employment authority allows the individual or their designated representative to recruit, hire, train, manage, supervise and fire employees.
- Budget Authority allows the individual or their designated representative flexibility over managing a yearly budget allocation. For example, they may request that more services be

authorized in one month and less in another or request to change from one approved waiver service to another as long as they stay within the authorized budget.

Self-direction includes six core components: person-centered planning, individual control of budgets, independent support brokerage, financial management services, a backup plan & quality enhancement & improvement.

Self-direction is firmly based in the principal of self-determination.

Self-determination refers to individuals or their designated representatives exercising control over their own lives, working toward achieving individualized life goals, and obtaining the skills and supports necessary to realize their visions for the future to build opportunities and relationships. The premise is that when individuals have control of their resources their quality of life will improve and the overall cost of services will decrease.

The following services may be self-directed:

- Personal Assistant
- Community Specialist
- Support Broker

The service coordinator will assist the individual or their designated representative in understanding the choice of self-directed supports and transitioning from provider driven to self-directed services. They can also hire a support broker to provide information and assistance in order for them to self-direct their supports.

When an individual chooses to self-direct supports the individual or their chosen representative is the employer.

The Division of DD contracts with a single Vendor Fiscal/Employer Agent (F/EA) Fiscal Management Service (FMS) organization to assist the employer with payroll-related functions. These functions include conducting a background screening of employee candidates, collecting and processing required human resource related forms and information (such as the IRS Form W-4, the US CIS Form I-9 and information necessary to register employees in the state‘s new hire reporting system), collecting and processing employees‘ time sheets, processing employees‘ payroll and the associated federal and state income tax withholding and employment taxes and other related payroll activities (such as issuing annual IRS Forms W-2 and refunding over-collected Medicare and Social Security taxes, as needed).

Section D: Organized Health Care Delivery System (OHCDS)

Waiver services may be provided by an Organized Health Care Delivery System (OHCDS) defined in 42CFR447.10. An OHCDS must provide at least one Medicaid service directly (utilizing its own employees) and may contract with other qualified providers to furnish other waiver services. County Boards for Developmental Disabilities who provide Targeted Case Management may enroll with MO HealthNet as a waiver OHCDS and may bill waiver services under the OHCDS provider number.

When OHCDS arrangements are used, all of the following apply:

- The OHCDS must have a written contract with any subcontractor who will provide waiver services.
- All subcontractors providing waiver services must meet applicable provider qualifications.
- A qualified provider cannot be forced to contract with an OHCDS, but may enroll directly with the state Medicaid agency, MO HealthNet.
- Waiver participants must be able to select any qualified provider who has contracted with the OHCDS, or select a provider that is not contracted with the OHDCS but has enrolled directly with MO HealthNet.
- The OHCDS must maintain all documentation of services furnished by the subcontractor.

The OHCDS may bill only for the cost of waiver services and must pass the reimbursement to the subcontractor, and may not retain excess payments and divert them to other uses. The amount billed to MO HealthNet cannot include administrative costs of the OHCDS.

Section E: Service Definitions

Assistive Technology

This service includes Personal Emergency Response Systems (PERS), Medication Reminder Systems (MRS) and other electronic technology that protects the health and welfare of a participant. This service may also include electronic surveillance/monitoring systems using video, web-cameras, or other technology. However, use of such systems may be subject to human rights review. Assistive technology shall not include household appliances or items that are intended for purely diversional or recreational purposes. Assistive technology should be evidenced based, and shall not be experimental.

Personal Emergency Response System (PERS) is an electronic device that enables an individual at high risk of institutionalization to secure help in an emergency that is connected to a device and programmed to signal a response center once the help button is activated. The response center must be staffed 24/7 with trained professionals. The service is limited to those who live alone, live with others who are unable to summon help, or who are alone for significant portions of the day, have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision.

A medication reminder system (MRS) is an electronic device programmed to provide a reminder to a participant when Medications are to be taken. The reminder may be a phone ring, automated recording or other alarm. This device is for individuals who have been evaluated as able to self administer medications with a reminder. The electronic device may dispense controlled dosages of medication and may include a message back to the center if a medication has not been removed from the dispenser.

Medications must be set-up by an RN or professional qualified to set-up medications in the State of Missouri.

All electronic device vendors must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc., (UL) standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by persons who are visually or hearing impaired or physically disabled.

Any assistive technology device must not interfere with normal telephone use.

The PERS and MRS must be capable of operating without external power during a power failure at the recipient's home in accordance with UL requirements for home health care signaling equipment with stand-by capability and must be portable.

An initial installation fee is covered as well as ongoing monthly rental charges and upkeep and maintenance of the devices.

Any assistive technology devices authorized under this service shall not duplicate services otherwise available through state plan.

MRS and PERS are just two of many different types of assistive technology. More examples of assistive technology that can enable people to be less dependent upon direct human assistance include but are not limited to electronic motion sensor devices, door alarms, web-cams, telephones with modifications such as large buttons, telephones with flashing lights, phones equipped with picture buttons programmed with that person's phone number, devices that may be affixed to a wheelchair or walker to send an alert when someone falls (these may be slightly different than a PERS) text-to-speech software, devices that enhance images for people with low vision, intercom systems.

Service Limitations:

Costs are limited to $3,000 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

Provider Requirements:

Agency - Provider type shall be electronic communication equipment and monitoring company, and must have a valid DMH contract to provide this service. The company shall be registered and in good standing with the Secretary of State Office.

Other Standard:

The monitoring agency must be capable of simultaneously responding to multiple signals for help from individuals' PERS equipment. The monitoring agency's equipment must include a primary receiver, a

stand-by information retrieval system and a separate telephone service, a stand-by receiver, a stand-by backup power supply, and a telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the PERS individual's Medical identification code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual and audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements including PERS equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures.

Assistive Technology Unit of Service:

Medicaid procedure code:

- Personal Electronic Safety Device, Installation: S5160
    - Unit of Service: 1 Install
    - Maximum Units of Service: One
- Personal Electronic Safety Device, Monthly Rental: S5161
    - Unit of Service: Monthly Rental fee
    - Maximum Units of Service: One/month

Assistive Technology Documentation:

The provider must maintain all documentation as per the requirements set forth in 13 CSR 70-3.030. Person Electronic Safety Device documentation includes but not limited to itemized invoices documenting the items purchased/rented and installed, and monthly service rates/expenses associated with device operation, upkeep and maintenance.

Behavior Analysis Services

This service is designed to help individuals demonstrating significant deficits (challenges) in the areas of behavior, social, and communication skills acquire functional skills in their homes and communities and/or to prevent hospitalizations or out-of-home placements. Behavior Analysis services may be provided to assist a person or persons to learn new behavior directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. Services may also be provided to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior.

- An individual's Behavior Analysis Services are based on the Functional Behavioral Assessment which identifies functional relationships between behavior and the environment including contextual factors, establishing operations, antecedent stimuli, contributing and controlling

consequences and possible physiological or medical variables related to the challenging behavior or situations.

- The plan should describe strategies and procedures to generalize and maintain the effects of the behavior support plan and to collect data to assess the effectiveness of the plan and fidelity of implementation of the plan.
- The specific skills and behaviors targeted for each individual should be clearly defined in observable terms and measured carefully by direct observation each session.
- The service shall include monitoring of data from continuous assessment of the individual's skills in learning, communication, social competence, and self-care guide to the scope of the individual support plan, which must include separate, measurable goals and objectives with clear definitions of what constitutes mastery.
- Data should be displayed in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph. The graph should provide indication of analysis via inclusion of environmental variables including medications and changes in medications, baseline or pre- intervention levels of behavior, and strategy changes.
- Performance based training for parents, caregivers and significant others in the person's life is also part of the behavior analysis services if these people are integral to the implementation or monitoring of the plan.

Senior Behavior Consultant and Behavior Intervention Specialist may be authorized in conjunction with a Functional Behavioral Assessment (FBA), which is a separate service, cost and code. The purpose of the FBA is to gather information in the form of data from descriptive assessment, observation and/or systematic manipulation of environmental variables, written and oral history of the individual. The information from the FBA should lead to identification of possible controlling and contributing variables, and possible proactive, preventative and reactive strategies for the identified challenges of the individual referred for Behavior Analysis Services.

NOTE: The Behavior Analysis Service is not intended to be an ongoing service. The following guidance shall be used when submitting authorizations to the Utilization Review Committee: Initial authorization for Behavior Analysis Service may not exceed 180 days,

- One subsequent authorization for Behavior Analysis Service may be approved, not to exceed an additional 90 days,
- Additional authorizations for Behavior Analysis Service must be approved by the Division Deputy Director or Assistant Director,
- Behavior Analysis Service may not be authorized concurrent with Applied Behavior Analysis.

Senior Behavior Consultant

The service consists of design, monitoring, revision and/or brief implementation of 1:1 behavioral interventions described in the individual's behavior support plan.

The service is designed to be utilized for situations involving complex behavioral issues such as severe aggression or self injury or when multiple behavioral challenges have been identified, many interventions have been unsuccessful or the challenges have a long history of occurrence. The Behavior Analysis service provides advanced expertise and consultation at critical points in the service delivery to achieve specific ends in the service delivery process such as assess a complex problem behavior, problem solve the lack of progress, or regression in the intervention. Ongoing management of behavior analysis services might generally be provided by the Behavior Intervention Specialist. Evaluation of these data is used to revise the individual's support plan and accompanying services to ensure the best outcome for the individual. Implementation of the behavior support plan may occur with all levels of this service, i.e., with the Behavior Intervention Specialist, with personal assistants, and/or with the family members.

Behavior Intervention Specialist

Provides ongoing management of behavior analysis services. In more complex or involved situations the Behavior Intervention Specialist is responsible for managing the direct implementation of the recommendations and strategies of a Behavior Analysis service, participating in the development of the behavior support plan and document as a team participant. In these more complex cases the Behavior Intervention Specialist serves as a "bridge" between the Senior Behavior Consultant and the other service providers and family and supports of the individual receiving services. In cases which do not require the advanced services of a Senior Behavior Consultant the Behavior Intervention Specialist may provide the Functional Behavioral Assessment and Behavioral Services without the oversight of a Senior Behavior Consultant except as required by licensure law and professional standards (BCABA practice standards require supervision by a BCBA). At a minimum, the Behavior Intervention Specialist will provide face-to-face in-home training on the behavior support plan to families and/or primary caregivers who have responsibility for implementing the behavior support plan in the home or community setting. This shall include training for meals, hygiene, school and/or community activities, and evenings and weekends noted in the behavior support plan as particularly challenging. Ongoing management of a behavior support plan is a key role for a Behavior Intervention Specialist. Ongoing management involves collecting and analyzing data for the effectiveness of the behavior support plan, fidelity of implementation of the behavior support plan and reliability of the data, adjustment or revision of the strategies identified in the behavior support plan, training caregivers and family members on the implementation of the behavior support plan, and on occasion implementation of the behavior support plan when complicated techniques are involved or for short trial periods to determine if the plan is viable and as part of the training of the main implementers for the behavior support plan.

Functional Behavioral Assessment

Functional Behavioral Assessment is a comprehensive and individualized strategy to identify the purpose or function of an individual's behavior, develop and implement a plan to modify variables that maintain the problem behavior, and teach appropriate replacement behaviors using positive interventions. The Functional Behavioral Assessment (FBA) which identifies functional relationships between behavior and the environment including contextual factors, establishing operations, antecedent stimuli, contributing

and controlling consequences, and possible physiological or medical variables related to the challenging behavior or situations. The FBA provides information necessary to develop strategies and recommendations to proactively address the challenging behaviors through skill development, prevention of problem situations and contributing reactions and interactions with significant persons in the life of the individual. These recommendations and strategies are more thoroughly delineated in the person's behavior support plan.

The process of the FBA includes gathering a written and oral history of the individual including data, interview of significant individuals who have been involved with the person during times of challenging behaviors as well as times when the person does not have challenging behaviors, observation of the person in a variety of situations, data collection and review, and for the most complex behaviors and situations a systematic manipulation of possible controlling and contributing variables. This information gathering process should lead to identification of possible controlling and contributing variables, and possible proactive, preventative and reactive strategies for the identified challenges of the individual referred for Behavior Analysis Services.

There will be situations in which an assessment will be needed to determine if other services or if behavior services might be appropriate. Not every instance of assessment will lead to behavioral services. If changes in situations occur, a new assessment may be warranted.

The FBA is a diagnostic assessment. Behavior analysts (including both senior consultant and behavior intervention specialist) conducting the FBA must be licensed in the State of Missouri (20 CSR 2063-4.005; 20 CSR 2063-5.010).

Service Limitation:

Functional Behavioral Assessments are limited to every two years unless the individual's behavior support plan documents substantial changes: to the individual's circumstances (living arrangements, school, caretakers); in the individual's skill development; in the performance of previously established skills; or in frequency, intensity or types of challenging behaviors. A Behavior Intervention Specialist, may under the direction of a Senior Behavior Consultant, conduct the data gathering for a functional assessment, however the final interpretation and recommendations must be the work of the Senior Behavior Consultant.

This service is not restricted by the age of the individual; however, it may not replace educationally-related services provided to individuals when the service is available under IDEA or other sources covered under an Individualized Family Service Plan (IFSP) through First Steps or otherwise available.

Behavior Analysis Provider Requirements:

An individual or an agency must have a DMH contract.

Senior Behavior Consultant-Doctorate: Can be provided by an agency or an individual who has a Missouri state license as a Behavior Analyst or a licensed professional in psychology, social

work, or professional counseling with training specific to behavior analysis as according to RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224

Senior Behavior Consultant-Masters: Can be provided by an agency or an individual who has a Missouri state license as a Behavior Analyst or a licensed professional in psychology, social work, or professional counseling with training specific to behavior analysis as according to RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224

Behavior Intervention Specialist: Can be provided by an agency or an Individual who has a Missouri state licensure as a Licensed Assistant Behavior Analyst or a licensed professional in psychology, social work or professional counseling with training specific to behavior analysis. RsMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224

Behavior Analysis Unit of Service:

Medicaid procedure code:

- Functional Behavioral Assessment: H0002
    - Unit of Service: One assessment
    - Maximum units: One assessment every 2 years.
- Senior Behavior Consultant: H2019
    - Unit of Service: 15 minutes
    - Maximum units: 32/ day
- Behavior Intervention Specialist: H2019
    - Unit of Service: 15 minutes
    - Maximum units: 48/day

Behavior Analysis Service Documentation:

Behavior Analysis providers must maintain service documentation as described in Section B of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the individual's service plan. Written data shall be submitted to DMH authorizing staff as required.

Community Employment

Community employment is competitive work in an integrated work setting with on-going support services for individuals with developmental disabilities. The service must be identified in the individual's service plan. Models of community employment may include individual jobs or group such as enclaves

(a cluster of jobs in an integrated setting, such as a plant), and mobile crew. Individual and group services are defined separately below.

Individual Community Employment:

Community employment services are delivered in the community at large when seeking employment and in integrated business work settings (including self-employment situations) where the individual with a developmental disability has chosen to become employed. Ongoing support consists of continuous or periodic job skill training as specified in the individual's service plan to enable the individual to perform the work.

Community Employment services may include:

- Individualized job development and placement;
- On-the-job training in work and work-related skills;
- Ongoing supervision and monitoring of the person's performance on the job; and
- Training in related skills needed to obtain and retain employment such as using community resources and public transportation.

Group Employment:

Group employment services are delivered in regular business and industry settings for groups of no more than six (6) workers with disabilities. Examples include enclaves and mobile work crews. The outcome of this service is sustained paid employment.

Group Employment services may include:

- Job development and placement;
- On-the-job training in work and work-related skills;
- Ongoing supervision and monitoring of the person's performance on the job; and
- Training in related skills needed to obtain and retain employment such as using community resources and public transportation.

Additional Information about employment services:

When participants are compensated they must be paid in accordance with the United States Fair Labor Standards Act (USFLSA) of 1985

Personal care/assistance may be a component of employment services, but may not comprise the entirety of the service. Individuals who receive job discovery and preparation services may also receive other day services. A participant's service plan may include two or more types of non-residential services. However, any combination of non-residential services may not be billed during the same period of the day.

Transportation costs are not included in the community employment fee, but specialized transportation is available as a separate service if necessary.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, the case records for individuals receiving community employment services under the waiver will document that the participant was denied benefits by the Missouri Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Service (VR), exhausted VR benefits (nine months is the maximum in Missouri), VR does not cover the specific employment service the individual requires, or the person requests supports from a provider that does not participate in VR's system. The service coordinator's documentation of VR's failure to confirm a denial of benefits in writing within 30 days of verbal notification may also serve as evidence of eligibility for community employment services.

Federal Financial Participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a community employment program; 2) Payments that are passed through to users of community employment programs; or 3) payments for training that is not directly related to an individual's community employment program.

Community Employment Staff Requirements:

Must be a qualified direct-care staff as defined in Section A of this manual.

Community Employment Provider Requirements:

Providers must have a DMH Home and Community Based Medicaid Waiver contract for the provision of community employment services and must have one of the following:

- A valid DMH license under 9 CSR 45-5.010 or certification by DMH under the Code of State Regulations, 9 CSR 45-5.010;
- Accreditation by the Commission on Accreditation of Rehabilitation Facilities
- (CARF) in the area of Community Employment Services; or
- The Council for Quality & Leadership for Persons with Developmental Disabilities (The Council).

Community Employment Unit of Service:

Medicaid procedure code:

- Community Employment, Individual: H2023
    - Unit of Service: 15 Minutes
    - Maximum Units of Service: 32/day
- Community Employment, Group: H2023
    - Unit of Service: 15 Minutes
    - Maximum Units of Service: 32/day

Community Employment Service Documentation:

Support Employment providers must document progress as referenced in Section B of this manual. Providers must also document hours worked, wages earned and deductions taken, and periodically assess the continued presence and extent of involvement of the job coach as part of the review process. Written data shall be submitted to DMH authorizing staff as required.

Community Specialist

A community specialist is used when specialized supports are needed to assist the individual in achieving outcomes in the service plan.

Community specialist services includes professional observation and assessment, individualized program design and implementation and consultation with caregivers. This service may also, at the choice of the individual designated representative, include advocating for the individual, and assisting the individual in locating and accessing services and supports within their field of expertise.

The services of the community specialist assist the individual and the individual's caregivers to design and implement specialized programs to enhance self direction, independent living skills, community integration, social, leisure and recreational skills and behavior management.

This service shall not duplicate other waiver services including but not limited to: Behavior Analysis or Personal Assistant services.

Service Limitation:

Community specialist, a direct waiver service, differs in service definition and in limitations of amount and scope from State plan targeted case management for person with developmental disabilities. In the latter, there are waiver administrative functions performed by a service coordinator through state plan TCM that fall outside the scope of community specialist, such as level of care determination, free choice of waiver and provider, due process and right to appeal. Additionally, MO Division of DD service coordinators facilitate services and supports, authorized in the service plan, through the regional office utilization review and authorization process.

A unit of service is 1/4 hour.

Community Specialist Provider Requirements:

The service may be provided by either an individual provider or an employee of an agency. There is an additional individual directed option for that allows the DDP- qualified community specialist to be an employee of the individual or family.

An individual with a Bachelors degree from an accredited university or college plus one year experience, or a Registered Nurse (with an active license in good standing, issued by the Missouri State Board of

Nursing) or an Associate's degree from an accredited university or college plus three years of experience.

An individual provider must also have a DMH contract.

An agency can be a Day Habilitation or Individual Supported Living agency may provide Community Specialist service that are certified by DMH or accredited by CARF or CQL. An agency can also be a State Plan Personal Care Provider; they must have a DMH contract and be enrolled as a Mo Healthnet Personal Care provider.

Community Specialist Unit of Service:

Medicaid procedure code:

- Community Specialist: T1016
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 96/day
- Community Specialist, Individual directed: T1016
    - Unit of Service: 15 minutes
    - Maximum Units of Services:96/day

Community Specialist Service Documentation:

Community Specialist providers must maintain documentation as referenced in Section B of this manual, including plan of treatment and detailed record of intervention activity by unit to include referrals to other agencies, recommendations for treatment change, progress on behavioral/service objectives which are part of the service plan. Annual assessments of individual/family status are required. When the Community Specialist's employer of record is the individual or the individual's family, the individual or family is responsible for ensuring adequate documentation in accordance with Section B is maintained. Written data shall be submitted to DMH authorizing staff as required.

(Community Specialist can be self-directed- for more information refer to Section C of this manual.)

Day Service

Day services are defined as any activity which enables individuals to achieve or maintain their optimal physical, emotional, and intellectual functioning. Day activities may include assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities and environments are designed to foster the acquisition of skills, greater independence and personal choice. Day services focus on enabling the participant to attain or maintain identified outcomes in their individual's plan. Coordination activities necessary to implement the individual plan may include family, professionals and others involved with the individual, as directed by the individual and the planning team. May include Activities of daily living (ADLs) and instrumental activities of daily living (IADLs) at the day program site

or in the community, and they may be provided individually or in small groups. Day services may be delivered with a staff ratio not to exceed 1:6. The planning team determines the content, site(s) and mode(s) of learning which best meet the needs of each individual. The planning team also assures that day services are coordinated with any therapies the person requires and that the day services do not duplicate, nor are duplicated by, any other services authorized for the individual.

A participant may also receive employment services while also authorized for day habilitation. The employment service provider may also be the day habilitation provider, or may be a different provider depending upon the choice of the participant. Documentation of services provided must clearly distinguish day habilitation from employment services, and may not be billed during the same period of the day.

For employment type activities an individual should use the employment service for job preparation and/ or job discovery since this service would more directly correlates to employment activities and allows for the tracking of employment specific activities.

Service Limitation:

Day habilitation services may not include educational services and may not supplant educational services individuals are entitled to receive. Transportation costs for community integration activities are included in the unit rate for day habilitation, but costs for transporting consumers from and to their residences are not included.

Personal assistant services cannot be provided at the same time as the day service.

Day Service Requirements:

Must be a qualified direct-care staff as defined in Section A of this manual.

Day Service Supervision:

Day habilitation services must be supervised by a Developmental Disabilities Professional (DDP) as defined in Section A of this manual.

Day Service Provider Requirements:

- Day habilitation providers must have a DMH Home and Community Based Medicaid Waiver contract for provision of day habilitation services and one of the following:
    - A valid DMH day habilitation license under 9 CSR 40-1, 2, 9 or Certification by the DMH under 9 CSR 45-5.010;
    - Accreditation by the Commission on Accreditation of Rehabilitation Facilities in the area of Personal, Social and Community Services; or
    - Accreditation by The Council for Quality & Leadership for Persons with Developmental Disabilities (The Council).

Day Service Unit of Service:

Medicaid procedure code:

- On-Site Day Habilitation, Group: T2021
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/day
- On-site Day Habilitation, Individual: T2021
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/day
- Off-Site Day Habilitation, Group: T2021
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/day
- Off-Site Day Habilitation, Individual: T2021
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/day

Day Service Documentation:

Day Habilitation providers must maintain service documentation as described in Section B of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the individual's service plan. Written data shall be submitted to DMH authorizing staff as required.

Dental

A. Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth.
B. Preventive dental treatment – Examinations, oral prophylaxes, and topical fluoride applications.
C. Therapeutic dental treatment – Treatment that includes, but is not limited to, pulp therapy for permanent teeth; restoration of carious permanent teeth; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable.

Service Limitations:

Dental services for individuals under the age of 21 are not covered. Dental services for individuals under the age of 21 may be accessed under the State plan as a Healthy Children and Youth (HCY/EPSDT) benefit.

Dental services through the Partnership for Hope Waiver for adults exclude the following:

- Any service that may be covered under the State plan Medicaid program:
    - This includes dental care related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or for treatment of a medical condition without which the health of the individual would be adversely affected. Dental services may

be provided to adults as State plan service if dental care is related to: traumatic injury or jaw, mouth, teeth, or other contiguous (adjoining) sites;
    - Medical conditions related to or for a transplant patient, chemo/radiation therapy patient, systemic diseases; AIDS, other autoimmune diseases, uncontrolled diabetics, paraplegic, quadriplegic and; any other medical condition if left untreated, the dental problems would adversely affect the health of the individual resulting in a higher level of care.

Service unit is one visit, with a maximum of one unit per day. The combined cost of all Partnership for Hope waiver services authorized for an individual, including dental services, is limited to $12,000 per year per participant. Dental services, authorized in combination with any other Partnership for Hope waiver service, are limited to $12,000 per year for the individual.

Dental Provider Requirements:

Individual Dentist

- Current licensure as a Dentist in the State of Missouri or bordering State.
- Have a DMH contract to provide this service
- The individual Dentist may be enrolled with MO HealthNet to provide State plan dental care.

Agency-Dental Clinic

- Dentists within the Dental Clinic must have current licensure as a Dentist in the State of Missouri or bordering Stat;
- Licensed Dental Hygienists or Dental Assistants services may be included.

Dental Clinic may be enrolled with MO HealthNet to provide State plan dental care.

Dental Unit of Service:

Medicaid procedure code:

- Dental Service: T2025
    - Unit of Service: 1 visit
    - Maximum Units of Service: 1/ day

Service Documentation:
The provider must maintain a plan of treatment and detailed record of all dental procedures by visit. Documentation must meet requirements set forth in 13 CSR 70-3.030.

Employer Provided Job Supports

The service allows the Division of DD, designated provider agencies to contract with a business to provide employer provided job supports as a part of the natural workplace. The supports will be provided directly to an individual to assist in the development of positive work-related habits, attitudes, skills and work etiquette directly related to their specific employment, as well as assisting the individual to become a part of the informal culture of the workplace. Employer provided job supports will include

orienting the individual to health and safety aspects/requirements of their particular job. Individuals participating in this service are employed by a business and are paid minimum wage or better.

This service differs from Community Employment in that it creates opportunity for services/supports to be provided by the local business' employee where the individual is employed. A peer employee at a business where the person with a developmental disability is employed will have a better understanding of the businesses culture, the organizational structure, and the informal culture than will the DD professional who provides Community Employment. Receiving mentoring from a fellow employee increases opportunities for acceptance into and thus success in the workplace community. It is intended to be of short duration.

This service enables a full continuum of job supports that could begin with job preparation, move to job discovery, then community employment with the least intensive support being provided through employer-provided job supports. It is not necessary for an individual to progress along this continuum, however. Depending upon the individual's skills, abilities and needs, identified during the person-centered planning process, they may start at any point, skip steps in the continuum, or transition back into a service where more supports are available.

Throughout the length of a contract, per funding requirements and with the employer's knowledge, the Division of DD or contracted provider performs oversight, just as they do in other waiver services.

This service is over and above the obligations an employer has for an employee without a disability, but does not duplicate nor supplant those provided under the provisions of the Individuals with Disabilities Education Improvement Act, or Section 110 of the Rehabilitation Act of 1973, or the Americans with Disabilities Act.

Service Limitations:

An individual may not receive Job Discovery, Job Preparation, or Community Employment, at the same time they receive Employer Provided Job Supports. Individuals receive Employer provided job supports services during their first six months of employment. Reimbursement may be extended up to 12 months on the job. After the first six months, the contract is reduced to a lower stabilization rate based on job support intervention needed.

Employer Provided Job Supports Provider Requirements:

Must have a DMH contract; to qualify, a description of supports to be provided by the subcontractor must be reviewed and accepted by the personal support team, including the service coordinator and other members designated by the individual, and the individual or his or her legal guardian prior to its execution.

These subcontracts are approved when it is determined that the individual's needs are best met by supports that supplement those provided by industry employees.

The provider must be an employer that is register with the Missouri Secretary of State as a business in good standing.

Employer Provided Job Support Unit of Service:

Medicaid procedure code:

- Employer Provided Job Support Service: Code to be developed
  - Unit of Service: 15 minutes
  - Maximum Units of Service: 32 units/day

Service Documentation:

Documentation must meet requirements set forth in 13 CSR 70-3.030.

Environmental Accessibility Adaptations

Those physical adaptations, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the community and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient, but shall exclude adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. Adaptations may be approved for living arrangements (houses, apartments, etc.) where the participant lives, owned or leased by the participant, their family or legal guardian. These modifications can be to the individual's home or vehicle.

All adaptations must be recommended by an Occupational or Physical Therapist. Plans for installations should be coordinated with the therapist to ensure adaptations will meet the needs of the individual as per the recommendation. All services shall be provided in accordance with applicable State or local building codes.

Service Limitations:

Costs are limited to $7,500 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

Environmental Accessibility Provider Requirements:

An individual or agency must have an applicable business license and meet applicable building codes; DMH contract.

Environmental Accessibility Unit of Service:

Medicaid procedure code:

- Environmental Accessibility: S5165
    - Unit of Service: One job
    - Maximum Units of Service: 1/month
    - Maximum Expenditure: $5,000 modifications per individual, per waiver year.

Environmental Accessibility Documentation:

Environmental Accessibility Adaptations providers shall maintain documentation as described in Section B of this manual as it applies to this service. The Division of DD Regional Office must be provided with an itemized invoice documenting the specific modifications that were provided prior to billing.

Job Discovery

Job discovery services include but are not limited to the following: Volunteerism, self-determination and self-advocacy (assisting an individual in identifying wants and needs for supports and in developing a plan for achieving integrated employment), job exploration, job shadowing, informational interviewing, labor market research, job and task analysis activities, employment preparation (i.e. resume development, work procedures), and business plan development for self-employment. Job discovery is intended to be time-limited. The initial discovery process should not exceed a three month period and will result in the development of a career profile and employment goal or career plan. Additional monthly increments must be preauthorized by the DDD.

If it becomes clear that competitive integrated employment is not a reasonable goal and the individual does not plan to move forward toward competitive integrated employment then other supports and services which are designed to continue on a long term basis should be considered.

The waiver will not cover vocational rehabilitation services, which are otherwise available under section 110 of the Rehabilitation Act of 1973. Therefore, the case records for individuals receiving job discovery and preparation services under the waiver will document that the participant was denied benefits by the Missouri Department of Elementary and Secondary Education, Office of Adult Learning and Rehabilitation Service (VR), exhausted VR benefits (nine months is the maximum in Missouri), VR does not cover the specific employment service the individual requires, or the person requests supports from a provider that does not participate in VR's system. The service coordinator's documentation of VR's failure to confirm a denial of benefits in writing within 30 days of verbal notification may also serve as evidence of eligibility for job discovery and preparation services.

When participants are compensated they must be paid in accordance with the United States Fair Labor Standards Act (USFLSA) of 1985.

Services may be provided in a community workplace setting or at a licensed, certified or accredited facility of a qualified job discovery and preparation service provider.

Services Limitations:

Job discovery is intended to be time-limited. The initial discovery process should not exceed a three month period and will result in the development of a career profile and employment goal or career plan.

Provider Requirements:

This service can be provided by an agency that has a DMH contract.

The Community Employment Provider shall be licensed according to 9 CSR 30-5.050; certified under 9 CSR 45-5.010; or accredited by CARF, CQL or Joint Commission.

Day Habilitation Provider shall be certified under 9 CSR 45-5.010; Accredited by the CARF in the area of Personal, Social and Community Services; or accredited by CQL or Joint Commission.

Job Discovery Unit of Service:

Medicaid procedure code:

- Job Discovery, Individual, On-site: T2019
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day
- Job Discovery, Individual, Off-site: T2019 SE
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/ Day

Job Discovery Documentation:

Job Discovery providers must maintain service documentation described in Section B of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the individual's service plan. Written data shall be submitted to DMH authorizing staff as required.

Job Preparation

Job preparation services provide training and work experiences intended to teach an individual the skills necessary to succeed in paid community employment. Skill training may include volunteerism, following directions, focusing on tasks, completing tasks, achieving productivity standards and quality results, responding appropriately to supervisors/co-workers, attendance and punctuality, problem solving, safety, mobility, or short term work trials. Training may also address workplace social skills necessary

for successful community employment such as appropriate work place attire, hygiene, and interaction with co-workers and supervisors, acceptable work behaviors and other skills such as accessing transportation and connecting to community resources as it relates to obtaining employment. This service should be a pathway towards individualized employment and is dependent on individuals demonstrating progress towards employment over time.

Services may be provided on site or off site in the community.

Transportation costs for Job Preparation services are included in the unit rate, but costs for transporting to and from the residence are not included.

Job preparation services must comply with 42 CFR §440.180(c) (2) (i). The need for services must be documented in the individual's service plan. Services must be primarily habilitation in nature.

Location and Group Size:

For on-site individual services have a 1:1 staff to participant ratio. The service may be provided on-site in the licensed, certified or accredited facility of a qualified job preparation service provider. Services may not be provided in a sheltered workshop.

For off-site individual services have a 1:1 staff to participant ratio and transportation costs needed to provide this service is included in the fee for service.

For on-site group size may vary between 1:2 and 1:6. The service may be provided on-site in the licensed, certified or accredited facility of a qualified job preparation service provider. Services may not be provided in a sheltered workshop.

For off-site group are delivered in a community workplace. Services may not be provided in a sheltered workshop. Group size may not exceed 1:4. Transportation costs needed to provide this service is included in the fee for service.

Staff Requirements:

Must be a qualified direct-care staff as defined in Section A of this manual.

Provider Requirements:
This service will be provided by an agency with a DMH contract.

The Community Employment Provider shall be licensed according to 9 CSR 30-5.050; certified under 9 CSR 45-5.010; or accredited by CARF, CQL or Joint Commission.

Day Habilitation Provider shall be certified under 9 CSR 45-5.010; Accredited by the CARF in the area of Personal, Social and Community Services; or accredited by CQL or Joint Commission.

Job Preparation Unit of Service:

Medicaid procedure code:

- Job Preparation, On-site Individual: H2025
    - Unit of Service: 15 minutes
    - Maximum Units: 48/Day
- Job Preparation, Off-site Individual: H2025 SE
    - Unit of Service: 15 minutes
    - Maximum Units: 48/Day
- Job Preparation, On-site Group: H2025 HQ
    - Unit of Service: 15 minutes
    - Maximum Units: 48/Day
- Job Preparation, Off-Site Group: H2025HQ SE
    - Unit of Service: 15 minutes
    - Maximum Units: 48

Service Documentation:

Job Preparation providers must maintain service documentation as described in Section B of this manual. Providers of any Job Preparation service must maintain documentation requirements as set forth in 13 CSR 70-3.030. Examples of documentation include attendance records, detailed progress notes associated with the objectives listed in the individual's service plan; and ongoing assessment of the individual's progress reported at least monthly. Written data shall be submitted to the authorizing staff as required.

Occupational Therapy

Occupational therapy requires prescription by a physician and evaluation by a certified occupational therapist (OT) or certified occupational therapeutic assistant (COTA) under the supervision of an OT. The service includes evaluation, plan development, direct therapy, consultation and training of caretakers and others who work with the individual. It may also include therapeutic activities carried out by others under the direction of an OT or COTA . Examples are using adaptive equipment, proper positioning and therapeutic exercises in a variety of settings.

Occupational therapy is covered under the Medicaid state plan for children and youth under the age of 21, so waiver OT is only for people age 21 and over.

Service limitations:

Occupational therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided.

Occupational therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first for persons before DD waiver occupational therapy is provided.

Occupational Therapy Provider Requirements:

Occupational therapy providers must have a DMH Home and Community Based Medicaid Waiver contract for provision of occupational therapy. To obtain this contract, providers must either be certified as an occupational therapist by the American Occupational Therapy Association or registered as a Certified Occupational Therapeutic Assistant (COTA) under RSMo 1990, 334.735-334.746.

Requirements that must be met by COTAs in Missouri are:

- Attainment of a two-year associate degree from an accredited college;
- Successful completion of a state exam; and
- Registration with the State Division of Professional Registration.
- In addition, COTAs must receive supervision from a professional OT that is on a periodic, routine and regular basis.

Occupational Therapy Unit of Service:

Medicaid procedure code:

- Occupational Therapy: 97535
    - Unit of Service: 15 minutes
    - Maximum Units of Service: Eight/day

Occupational Therapy Documentation:

Occupational Therapy providers must maintain service documentation as described in Section B of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the individual's service plan. Written data shall be submitted to DMH authorizing staff as required.

Personal Assistant

Personal Assistant Services include assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, care of adaptive equipment, meal preparation, feeding, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, cueing and minor problem-solving necessary to achieve increased independence, productivity and inclusion in the community. While ordinarily provided on a one-to-one basis, personal assistance may include assisting up to three individuals at a time.

Personal assistance may also include general supervision and protective oversight. The personal assistant may directly perform some activities and support the individual in learning how to perform others; the planning team determines the composition of the service and assures it does not duplicate, nor is duplicated by, any other service provided to the individual.

Team Collaboration allows the individual's employees to participate in the service plan and to meet as a team to ensure consistency in its implementation. A team meeting also can be convened by the individual or their designated representative for the purposes of discussing specific needs of the individual, the individualized progress towards outcomes related concerns.

Team collaboration is covered under the administrative component of personal assistant paid to agency-based personal assistant. For people who are self-directing personal assistant services, team collaboration can be included in the individual budget up to 90 hours per plan year.

Relatives as Providers

Personal assistant services shall not be provided by an individual's spouse, if the individual is a minor (under age 18) by a parent, or legal guardian. Personal assistant services may otherwise be provided to a person by a member(s) of his or her family when the person is not opposed to the family member providing the service and the service to be provided does not primarily benefit the family unit, is not a household task family members expect to share or do for one another when they live in the same household, and otherwise is above and beyond typical activities family members provide for another adult family member without a disability.

In case of a paid family member the service plan must reflect:

- The individual is not opposed to the family member providing services;
- The services to be provided are solely for the individual and not task household tasks expected to be shared with people live in family unit;
- The planning team determines the paid family member providing the service best meet the individual's needs;
- A family member will only be paid for the hours authorized in the service plan and at no time can these exceed 40 hours per week. Any support provided above this amount would be considered a natural support or the unpaid care that a family member would typically provide;
- Family members can be hired for personal assistant only.

Family is defined as: A family member is defined as a parent, step parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

Family members approved to provide personal assistant services may be employed by an agency or employed by the individual/guardian or designated representative using an approved fiscal management service provider. If the person employs his/her own workers using an approved fiscal management service provider, the family member serving as a paid personal assistant shall not also be the designated representative/common law employer.

Relation to State Plan Personal Care Services

Personal care services under the state plan differ in service definition, in limitations of amount and scope, and in provider type and requirements from personal assistant services under the waiver. When an individual's need for personal assistance is strictly related to ADLs and can be met through the MO

HealthNet state plan personal care program administered by the Division of Senior and Disability Services (DSDS), he or she will not be eligible for personal assistant services under the waiver, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided.

DD Waiver personal assistant may be authorized when:

- Person needs assistance with IADLs (State plan services do not provide assistance with IADLs);
- State plan limits for personal care are reached and more assistance with ADLs are needed;

When waiver personal assistant is authorized to adults also eligible for state plan personal care, the service coordinator must consult and coordinate the waiver service plan with the DSDS service authorization system.

Personal care services are provided to children with disabilities according to the federal mandates of the Early Periodic Screening, Diagnosis and Treatment program. Personal Assistant needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Personal Assistant services through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver Personal Assistant service is provided. State plan personal care services for children are coordinated through the Bureau of Special Health Care Needs (BSHCN).

When waiver personal assistant is authorized for children also eligible for state plan personal care, the service coordinator must consult and coordinate with the BSHCN service authorization system.

Non-Duplication of Services

Personal Assistant services shall not duplicate other services. Personal assistance is not available to waiver recipients who reside in community residential facilities (Group Homes and Residential Care Centers). Persons who receive Individualized Supported Living (ISL) services shall not receive personal assistant services at their home but may receive this service outside the home - as long as not included in the ISL budget.

Personal Assistant Qualifications and Training

Training will cover, at a minimum:

a. Training, procedures and expectations related to the personal assistant in regards to following and implementing the individual's Service Plan.
b. The rights and responsibilities of the employee and the individual, procedures for billing and payment, reporting and documentation requirements, procedures for arranging backup when needed, and who to contact within the Regional Office or Targeted Case Management entity.
c. Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.

d. Training in abuse/neglect, event reporting, and confidentiality.
e. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
f. CPR and first aid;
g. Medication Administration;
h. Behavioral Intervention Training As needed, due to challenging behavior by the Individual, the assistant will also be trained in behavioral intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
i. training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
j. Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual to be served and indentified by the team.

For SDS: The planning team will specify the qualifications and training the personal assistant will need in order to carry out the service plan, where/by whom the assistant will be trained, and the source, method and degree of monitoring but not less than quarterly. To the extent they desire, the individual or designated representative will select the personal assistant and carry out training and supervision.

Individual/guardian or designated representative may exempt the following trainings if:

a. Duties of the Personal Assistant will not require skills to be attained from the training requirement;
b. The personal assistant named above has adequate knowledge or experience in:
    - CPR and first aid;
    - Medication Administration;
    - Behavioral Intervention Training As needed, due to challenging behavior by the Individual, the assistant will also be trained in behavioral intervention techniques such as NCI (Nonviolent Crisis Intervention), MANDT, or others approved by the Division of DD;
    - As needed, training in communications skills; in understanding and respecting Individual choice and direction; cultural and ethnic diversity, personal property and familial and social relationships; in handling conflict and complaints;
    - Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the individual to be served and indentified by the team.

Limitations Services:

When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's need for the service as an alternative to institutional care and the overall cost effectiveness of his or her service plan.

Personal Assistant can occur in the person's home and/or community, including the work place. Personal Assistant shall not be provided concurrently with or as a substitute for facility-based day habilitation services.

Payment is on a 15 minute, fee for service basis, with different rates for individual and small group services, and, when needed, for enhanced staff qualifications.

Children under the age of 21 have access to EPSDT services through the State Plan. Waiver PAS is only provided to children when the need is in excess or beyond the scope of state plan limits.

Personal Assistant Provider Qualifications:

Personal assistance may be provided either by an individual contractor employed by the individual or family or by an employee of an agency. The determination of which type of provider will deliver the service will be the choice of the individual and/or his family or guardian, with the limitation that for an individual provider to be used, the individual and/or family or guardian must be able and willing to supervise the provider and the planning team must certify that this supervision will be sufficient to safeguard the individual's health and safety.

Provider Supervision:

Supervision will be provided by a DDP or by the individual or his or her family or guardian. In either case, the frequency and scope of the supervision will be specified in the service plan.

Provider Requirements:

This service can be self directed if the individual chooses. For more information regarding self directing this service see the section D.

This service can be provided by an individual or an agency.

A provider of this service must have a DMH contract.

An agency can be a Day Habilitation or Individual Supported Living provider to provide Personal Assistance service that are certified by DMH or accredited by CARF, CQL or Joint Commission. An agency can also be a State Plan Personal Care Provider and be enrolled as a Mo Healthnet Personal Care provider.

An individual may be an Independent Contractor who has a Missouri State professional license such as RN or LPN.

Employee of Individual/Family who is 18 years of age; meets minimum training requirements; agreement with Division RO; agreement with individual/designated representative; Planning team will specify the qualifications and training the personal assistant will need in order to carry out the service plan; Supervision is provided by the individual, family or a designated support broker in providing service in the home or community consistent with the service plan.

Relative Employed by Individual/Family who is 18 years of age; meets minimum training requirements; agreement with Division RO; agreement with individual/designative representative; Shall not be the individual's spouse; a parent of a minor child (under age 18); a legal guardian; nor the employer of record for the individual. The individual shall not be opposed to the family member providing care. The planning team agrees the family member providing the personal assistant service will best meet the individual's needs. Family members employed by the individual or designated representative are supervised by the individual or a designated representative in providing service in the home or community consistent with the service plan. Family members employed by an agency are supervised by the agency.

Personal Assistant Specialized Medical/Behavioral:

Specialized Medical/Behavioral Personal Assistant includes services previously defined under personal assistant for an individual who has certain medical or behavioral needs. Due to these enhanced needs there are additional requirements that must be met prior to this service being implemented.

Specialized Behavioral Personal Assistant:

To assist in evaluating the need for specialized behavioral personal assistance the following must have been met:

- The interdisciplinary team has documented efforts to maximize the individual's ability to communicate with others;
- The interdisciplinary team has documented implementation of preventive strategies and outcomes of those strategies;
- The interdisciplinary team has identified and outlined the need to pursue more intensive behavior support strategies in the plan;
- An initial screening for medical, psychiatric or pharmacological causes has been completed, and;
- Prior to approval of funding for specialized behavioral personal assistance the individual plan has gone through the local Service Plan review process and has been reviewed by the Regional Behavior Supports Review Committee to determine the above have been completed.

The specialized behavioral/medical personal assistant *must* adhere to the same requirements as outlined for the Individual Provider Employed by Individual or Family. Additional requirements are as follows:

- Received training and holds current certification on behavioral support intervention strategies or Tools of Choice training that is approved by DMH and;
- Agency DDP has participated and successfully completed a DMH approved Positive Behavior Support Training or Tools of Choice training, and;
- Must be trained on the specific individual's behavior support strategies.

Specialized Medical Personal Assistant:

To assist in evaluating the need for specialized medical personal assistance the following must have been met:

- The interdisciplinary team has identified that the individual's level of care requires either the:
- Direct delivery of care by a licensed medical professional* or,
- Training, delegation and periodic supervision of care by a licensed medical professional*.
  * Licensed Medical Professional as defined by the Nursing Practice Act Chapter 335. RSMo.
- The service plan documents the need and timeline for review of service.

The specialized medical personal assistant must adhere to the same requirements as outlined for the Individual Provider Employed by Individual or Family. Additional requirements are as follows:

- Received training related to the individual's medical needs as outlined in the Service Plan and as prescribed by the physician or advanced practice nurse.
- Received training by a licensed medical professional, demonstrated competency in all instructed procedures and are being delegated the task as determined by the supervising licensed medical professional*. This delegation and individualized instruction is specific to this individual and may not be transferred to other individuals.

All training must be documented and available upon request.

Personal Assistant Unit of Service:

Medicaid procedure code:

- Personal Assistant, Individual, Self Directed: T1019
  - Unit of Service: 15 minutes
  - Maximum Units of Service: 96/day
- Personal Assistant, Agency/Contractor: T1019
  - Unit of Service: 15 minutes
  - Maximum Units of Service: 96/day
- Personal Assistant, Agency/Contractor Group: T1019
  - Unit of Service: 15 minutes
  - Maximum Units of Service: 96/day
- Personal Assistant, Medical/Behavior, Self Directed: T1019
  - Unit of Service: 15 minutes
  - Maximum Units of Service: 96/day
- Personal Assistant, Medical/Behavior, Agency/Contractor: T1019
  - Unit of Service: 15 minutes
  - Maximum Units of Service: 96/day

Personal Assistant Documentation:

Personal Assistant providers must maintain documentation as referenced in Section B of this manual. When the personal assistant's employer of record is the individual or the individual's family, the individual or family is responsible for ensuring adequate documentation in accordance with Section 13.9.A. is maintained. Written data shall be submitted to DMH authorizing staff as required.

(Personal Assistant can be self-directed- for more information refer to section C)

Physical Therapy

Physical Therapy treats physical motor dysfunction through various modalities as prescribed by a physician and following a physical motor evaluation. It is provided to individuals who demonstrate developmental, habilitative or rehabilitative needs in acquiring skills for adaptive functioning at the highest possible level of independence.

Services may include consultation provided to families, other caretakers, and habilitation services providers. Physical therapy services may not be carried out by a paraprofessional. A unit of service is 1/4 hour.

Therapies available to adults under the state plan are for rehabilitation needs only. Therapies in the waiver are above and beyond what the state plan provides. Therapies in the waiver are more habilitative in nature; habilitative therapy is not available under the state plan.

Service Limitations:

Physical therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Physical therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver physical therapy is provided. Children have access to EPSDT services.

Physical Therapy Provider Requirements:

Physical therapy providers must have a DMH Home and Community Based Medicaid Waiver contract for the provision of physical therapy services and must be registered as a physical therapist with the Division of Professional Registration in the State of Missouri, RSMo, 1990, 334.530-334.625.

Physical Therapy Unit of Service:

Medicaid procedure code:

- Physical Therapy: 97110
    - Unit of Service: 15 minutes
    - Maximum Units of Service: Eight/day

Physical Therapy Documentation:

Physical Therapy providers must maintain service documentation as described in Section B of this manual.

Positive Behavior Support

This service provides, consultation for strategies of Positive Behavior Support Strategies (Universal level supports and Focused teaching and environmental strategies) to and for individuals whose undesirable behaviors are disrupting their progress in habilitation, self direction or community integration and/or are threatening (at increased risk for) to require movement to a more restrictive placement. This service may also include consultation provided to families, other caretakers and habilitation service providers.

Positive Behavior Support strategies categorized as described in Universal level supports are those that involve evaluating residential or family systems for general system changes that could promote more positive interactions and behaviors clarify expectations and establish positive expectations or rules, improve recognition of desirable behaviors and reduce problematic interactions by support person that might evoke undesirable behaviors. All persons involved in the system would benefit from Universal level supports.

Focused training and environmental strategy supports are required if Universal level supports consistently utilized and have not resulted in sufficient change such that the undesirable behaviors are still problematic. Focused supports involve consultation, monitoring and training to establish increased opportunities for teaching and practice of desirable behaviors, group involvement in recognition and practice opportunities such as social skills training groups or establishes a system of coaching and prompting for desirable behaviors in situations that commonly are associated with problem behaviors. The behavior therapist might establish and lead such practice opportunities while coaching support person to continue the practice when the service is discontinued.

This service is not to be provided for development or implementation of behavior support strategies or functional assessment as these services require licensure as a behavior analyst, psychologist, counselor or social worker with specialized training in behavior analysis. The unit of service is one-fourth hour. This is a short term service that is not meant to be on going, the typical duration of service is to be six months or less.

Positive Behavior Support differs from the Behavior Analysis Service in that PBS will require providers with a less involved level of training and experience than BAS.

Service Limitations:

This is a short term service that is not meant to be on going, the typical duration of service is to be six months or less.

Psychology/Counseling services under EPSDT do not include Positive Behavior Support services.

Provider Requirements:

An agency or an individual must have a DMH contract.

This service can be provided by an Individual or an agency who is a Qualified Positive Behavior Support Professional. A Qualified Positive Behavioral Support Professional is a person with a bachelor's degree with special training, approved by the Division, related to the theory and practice of Positive Behavior Supports for individuals with intellectual and developmental disabilities, or Applied Behavior Analysis and implementation of Person Centered Approaches.

Positive Behavior Support Unit of Service:

Medicaid procedure code:

- Positive Behavior Support: H0004 HK
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/Day

Positive Behavior Support Documentation:

Positive Behavior Support providers must maintain service documentation described in Section B of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the individual's service plan. Written data shall be submitted to DMH authorizing staff as required.

Professional Assessment and Monitoring

Professional Assessment and Monitoring - A face to face visit to evaluate need and identify appropriate assistance including any special instructions for participants and their caregivers to reduce the need for routine health professional visits and prevent a higher level of care, which may include limited physical assessments, medication set up, injections, limited diagnosis and treatment, nutritional care plans, nutritional counseling if the nutritional problem or condition is of such a degree of severity that counseling is beyond that normally expected as a part of standard medical management, and nutritional therapy services, not otherwise covered by Medicare or Medicaid state plan services. Any changes in health status are to be reported to the physician and service coordinator as needed. Written reports of the visit are required to be sent to the service coordinator. This service may be provided by a licensed registered professional nurse, or a licensed practical nurse under the supervision of a registered nurse, or a licensed dietitian to the extent allowed by their respective scope of practice in the State of Missouri.

This service must not supplant Medicaid State plan services or Medicare services for which an individual is eligible. Excluded services include Diabetes Self Management Training available under the state plan and medical nutrition therapy services prescribed by a physician for Medicare eligible's who have diabetes or renal diseases.

Service Limitations:

This service must not supplant Medicaid State plan services or Medicare services for which an individual is eligible. Excluded services include Diabetes Self Management Training available under the state plan and medical nutrition therapy services prescribed by a physician for Medicare eligible's who have diabetes or renal diseases.

Children under the age of 21 have access to private duty nursing and home health through the state plan. Professional assessment and monitoring shall not duplicate or supplant state plan services.

Professional Assessment and Monitoring Provider Requirements:

Be a Licensed in Missouri as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Dietician and have a DMH contract.

Provider Requirements:

Professional Assessment and Monitoring service providers must have a valid DMH contract and/or provide services through an Organized Health Care Delivery system for the provision of Professional Assessment and Monitoring services. The contractor shall not be the individual's spouse, a parent of a minor child (under age 18), nor a legal guardian.

Professional Assessment and Monitoring Unit of Service:

Medicaid procedure code:

- Professional Assessment and Monitoring, Registered Nurse: T1002
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/day
- Professional Assessment and Monitoring, LPN: T1003
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/day
- Professional Assessment and Monitoring, Dietician: S9470
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 48/day

Professional Assessment and Monitoring Documentation:

Providers of Professional Assessment and Monitoring must maintain a plan of treatment and detailed record of intervention activities by unit of service. Service documentation must meet requirements as set forth in 13 CSR 70-3.030.

Specialized Medical Equipment and Supplies (Adaptive Equipment)

Specialized medical equipment and supplies includes devices, controls, or appliances, specified in the service plan, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, durable and non-durable medical equipment and supplies, and equipment repairs when the equipment, supplies and repairs are not covered under the Medicaid State DME plan. Includes incontinence supplies.

Items reimbursed with waiver funds, shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. All items shall meet applicable standards of manufacture, design and installation.

Service Limitations:

Costs are limited to $7,500 per year, per individual. The annual limit corresponds to the waiver year, which begins July 1 and ends June 30 each year.

Other specialized equipment, supplies and equipment repair needs for the eligible person that can be met through state plan, including EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. DD waiver other specialized equipment, supplies and repairs shall be provided above and beyond any state plan, including EPSDT, equipment, supplies, and repair service that can meet the individual's needs. Further, this waiver service may also be authorized for items/repairs not covered under state plan and falls within the waiver service definition described above.

Specialized Medical Equipment and Supplies Provider Requirements:

Providers of specialized medical equipment and supplies must have a DMH Home and Community Based Medicaid Waiver contract specific to the provision of the specialized medical equipment and supplies. The company must also be registered and in good standing with the Missouri Secretary of State's Office.

Specialized Medical Equipment and Supplies Unit of Service:

Medicaid procedure code:

- Specialized Medical Equipment and Supplies: T2029
    - Unit of Service: 1 Job
    - Maximum Units of Service: 1/Month
    - Maximum expenditure: $7,500 of items or adaptations per individual per waiver year

Specialized Medical Equipment and Supplies Documentation:

Specialized Medical Equipment providers shall maintain documentation as described in Section B of this manual as it applies to this service. The Division of DD Regional Office must be provided with an itemized invoice documenting items purchased and/or installed, prior to billing.

Speech Therapy

Speech Therapy is for individuals who have speech, language or hearing impairments. Services may be provided by a licensed speech language therapist or by a provisionally licensed speech therapist working with supervision from of a licensed speech language therapist. The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. The need for services must be identified in the plan of care and prescribed by a physician. Speech therapy provides treatment for delayed speech, stuttering, spastic speech, aphasic disorders, and hearing disabilities requiring specialized auditory training, lip reading, signing or use of a hearing aid.

Services may include consultation provided to families, other caretakers, and habilitation services providers. A unit of services is 1/4 hour.

Waiver providers must be licensed by the State of Missouri as a Speech Therapist. The Medicaid Waiver enrolled provider may employ a person who holds a provisional license from the State of Missouri to practice speech-language pathology or audiology. Persons in their clinical fellowship may be issued a provisional license. Clinical fellowship is defined as the supervised professional employment period following completion of the academic and practicum requirements of an accredited training program. Provisional licenses are issued for one year. Within 12 months of issuance, the applicant must pass an exam promulgated or approved by the board and must complete the master's or doctoral degree from an institution accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association in the area in which licensing is sought. Provisionally licensed speech therapists must receive periodic, routine supervision from their employer, a Medicaid waiver enrolled speech therapy provider.

Therapies available to adults under the state plan are for rehabilitation needs only. Therapies in the waiver are above and beyond what the state plan provides. Therapies in the waiver are more habilitative in nature; habilitative therapy is not available under the state plan.

Service Limitations:

The individual's need for this therapy must be determined in a speech/language evaluation conducted by a certified audiologist or a state certified speech therapist. Services must be required in the plan of care and prescribed by a physician. This service may not be provided by a paraprofessional.

Speech therapy needs for the eligible person through EPSDT, as applicable, shall first be accessed and utilized, in accordance with the requirement that state plan services must be exhausted before waiver services can be provided. Speech therapy through EPSDT for eligible persons under age 21 shall be provided and exhausted first before the waiver speech therapy is provided. Children have access to EPSDT services.

Speech Therapy Provider Requirements:

Speech and language therapy providers must have a DMH Home and Community Based Medicaid Waiver contract for provision of speech and language therapy. A provider must be licensed by the State of Missouri as a Speech Therapist. The Medicaid Waiver enrolled provider may employ a person who holds a provisional license from the State of Missouri (RSMo 1990 345.050) to practice speech-language pathology or audiology. Persons in their clinical fellowship may be issued a provisional license. Clinical fellowship is defined as the supervised professional employment period following completion of the academic and practicum requirements of an accredited training program. Provisional licenses are issued for one year. Within 12 months of issuance, the applicant must pass an exam promulgated or approved by the board and must complete the master's or doctoral degree from an institution accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association in the area in which licensing is sought. Provisionally licensed speech therapists must receive periodic, routine supervision from their employer, a Medicaid waiver enrolled speech therapy provider.

Speech Therapy Unit of Service:

Medicaid procedure code:

- Speech Therapy: 92507
    - Unit of Service: 15 minutes
    - Maximum Units of Service: Eight/day

Speech Therapy Documentation:

Speech Therapy providers must maintain service documentation as described in Section B of this manual, including detailed progress notes (reported at least monthly) associated with objectives listed in the individual's service plan. Written data shall be submitted to DMH authorizing staff as required.

Support Broker

A Support Broker provides information and assistance to the individual or designated representative for the purpose of directing and managing supports. This includes practical skills training and providing information on recruiting and hiring personal assistant workers, managing workers and providing information on effective communication and problem-solving. The extent of the assistance furnished to the individual or designated representative is specified in the service plan.

A Support Broker provides the individual or their designated representative with information & assistance (I&A) to secure the supports and services identified in the Service Plan.

A Support Broker provides the individual or designated representative with information and assistance (I &A) to:

- establish work schedules for the individual's employees based upon their Service Plan
- help manage the individual's budget when requested or needed
- seek other supports or resources outlined by the Service Plan
- define goals, needs and preferences, identifying and accessing services, supports and resources as part of the person centered planning process which is then gathered by the service coordinator for the Service Plan
- implement practical skills training (recruiting, hiring, managing, terminating workers, managing and approving timesheets, problem solving, conflict resolution)
- develop an emergency back-up plan
- implement employee training
- promote independent advocacy, to assist in filing grievances and complaints when necessary
- include other areas related to providing I&A to individuals/designated representative to managing services and supports

Support brokers must have a background screening per the Division of DD, be at least 18 years of age and possess a high school diploma or GED.

The support broker must have experience or Division DD approved training in the following areas:

- ability, experience and/or education to assist the individual/designated representative in the specific areas of support as described in the Service Plan
- competence in knowledge of Division of DD policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- understanding of support broker responsibilities, of advocacy, person-centered planning, and community services
- understanding of individual budgets and Division of DD fiscal management policies

The planning team may specify any additional qualifications and training the support broker will need in order to carry out their duties as specified in the Service Plan.

Service Limitations:

Support Broker services do not duplicate Service Coordination. Support Brokerage is a direct service.

A Support Broker may not be a parent, guardian or other family member. They cannot serve as a personal assistant or perform any other waivered service for that individual. This service can be authorized for up to 8 hours per day (32 quarter hour units).

Support Broker Provider Requirements:

A person must be over age 18 with a High School diploma or GED who the individual or their designated representative chooses to hire, with the following *exceptions*: An individual's spouse, parents or other family member if they are a minor, an individual's legal guardian or anyone with legal authority over them, individual's designated representative or anyone with a felony or charge which is disqualifying

Support Broker Unit of Service:

Medicaid procedure code:

- Support Broker, Individual, Self directed: T2014U2
    - Unit of Service: 15 Minutes
    - Maximum Units of Service: 32/day
- Support Broker, Agency: T2041
    - Unit of Service: 15 minutes
    - Maximum Units of Service: 32/day

Support Broker Documentation:

All services provided must be adequately documented. The documentation must be sufficient so that it is understandable, explains what was provided, and can be verified with reasonable certainty that the services were in fact provided. The individual/designated representative is responsible for ensuring adequate documentation in accordance with the Section B of this manual is maintained. All documentation is maintained by the employer (individual or their designated representative)

(Support Broker can be self-directed for more information refer to section C of this manual.)

Temporary Residential Service

Temporary Residential Service is care provided outside the home in a licensed, accredited or certified waiver residential facility, ICF/MR or State Habilitation Center by trained and qualified personnel for a period of no less than one day (24 hours), and no more than 60 days per year. The need for this service has to be an identified need through the planning process which would include the individual, guardian if applicable, the primary caregiver, other family members, service coordinator, and any other parties the individual requests. The purpose of temporary residential is to provide planned relief to the customary caregiver and is not intended to be permanent placement. If the needs of the individual exceed the Partnership for Hope Waiver annual cap or the individual's service plan identifies an ongoing need for out of home services then the planning team would work to transition the individual to another DD waiver to meet their needs. FFP is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Staff Requirements:

Must be a qualified direct-care staff as defined in Section A of this manual.

Provider Requirements:

Temporary Residential service providers must have a DMH Home and Community Based Medicaid Waiver contract for the provision of temporary residential and one of the following:

- A valid DMH community residential facility license under 9 CSR 40-1,2,4,5 or certified by the DMH under 9 CSR 45-5.010.
- Accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF), in the area of Community Living Programs; or
- The Council for Quality & Leadership for Persons with Developmental Disabilities (The Council); or
- Certified ICFs/MR and Division of Developmental Disabilities Habilitation Centers may be enrolled to provide temporary residential.

Service Limitations:

Temporary Residential may not be provided for a period of less than 1 day (24 hours) and no more than 60 days per year.

Temporary Residential Unit of Service:

Medicaid procedure code:

- Temporary Residential: H0045
    - Unit of Service: Day
    - Maximum Units of Service: One/day

Temporary Residential Documentation:

Providers of the temporary residential service must maintain attendance records and progress notes. The provider is required to follow procedures set forth under in Section B of this manual.

Transportation

Transportation is reimbursable when necessary for an individual to access waiver and other community services, activities and resources specified by the service plan. Transportation under the waiver shall not supplant transportation provided to providers of medical services under the state plan as required by 42 CFR 431.53, nor shall it replace emergency medical transportation as defined at 42 CFR 440.170(a) and provided under the state plan. State plan transportation in Missouri is provided to medical services covered under the state plan, but not to waivered services, which are not covered under the state plan. Transportation is a cost effective and necessary part of the package of community services, which prevent institutionalization.

A variety of modes of transportation may be provided, depending on the needs of the individual and availability of services. Alternatives to formal paid support will always be used whenever possible. A unit is one per month.

Service Limitations:

Transportation available under the state plan is limited to medical services covered in the state plan. State plan transportation does not cover transporting persons to waiver services. Transportation under the waiver shall not be used to transport waiver participants to medical services under the state plan as required by 42 CFR 431.53, nor shall it replace emergency medical transportation as defined at 42 CFR 440.170(a) and provided under the state plan.

Transportation Requirements:

Providers must satisfy all State of Missouri licensure requirements and applicable State of Missouri statutes for both drivers and vehicles under RSMo, Chapter 302. Providers must have a DMH Home and Community Based Medicaid Waiver contract for the provision of transportation services.

Transportation Unit of Service:

Medicaid procedure code:

- Transportation: A0120
    - Unit of Service: Month of transportation
    - Maximum Units of Service: One/month

Transportation Service Documentation:

Transportation providers shall follow procedures as described in Section B of this manual as it applies to this service. To document service delivery, a transportation provider must maintain:

- Individual trip records for each individual transported;
- Mileage or zone records of miles or zones provided; and
- Accurate records of transportation costs.