

The Alabama Department of Mental Health's Division of Developmental Disabilities (DDD) Provider Operational Guideline Manual

Serve • Empower • Support



**Promoting the health and well-being of Alabamians with mental illness,
developmental disabilities and substance use disorders.**

DDD implements the Mission and Vision of the Alabama Department of Mental Health by assuring that people with Developmental Disabilities are provided quality supports and services to lead meaningful lives through their choice of employment, home and relationships.

Effective November 1, 2019

**The Alabama Department of Mental Health
Division of Developmental Disabilities**

Operational Guidelines Manual

ELIGIBILITY, ENROLLMENT AND DISENROLLMENT	6
1.1. Intake/Information and Referral.....	6
1.2. Waiting List.....	8
1.2.a. Criteria for Determining Eligibility and Placement on the Waiting List	8
1.2.b. Wait List Eligibility Applications from ADMH Inpatient Facilities	9
1.2.c. Waiting List – Entry to Services	9
1.2.d. Wait List Selection Process	10
1.3. Inventory for Client and Agency Planning (ICAP) for Community Services	12
1.4. Criticality Assessment	13
1.5. Request for Psychological Testing.....	14
1.6. Waiver Services.....	15
1.6.a. Wait List for Services to Children	15
1.6.b. Waiver to Waiver Transfers	16
1.6.c. Termination of Waiver	16
1.6.d. Waiver Admission & Discharge.....	17
INDIVIDUAL RIGHTS	18
2.1. Appeals.....	18
2.1.a. Waiver/Wait List Eligibility Appeals	18
2.1.b. Appeals Process for Adverse Actions- Services Decisions	19
2.2. Dissatisfaction of Services.....	21
2.3. Informal Conference- Services.....	23
2.4 Other	24
2.4.1 Forensic Cases	24
INDIVIDUAL SUPPORT PLANNING AND IMPLEMENTATION	25
3.1. Plan of Care	25
SUPPORT COORDINATION AND CASE MANAGEMENT	26
4.1. Funding for Support Coordination Agencies.....	26
4.2. Request for Action/Services.....	27
4.3. Redetermination	29
4.4. Summary Program of Habilitation	31
4.5. Monitoring - Individual Experience Assessment Survey	32
4.6. RFA Recoupment Policy	40

PROVIDER REQUIREMENTS AND OTHER INFORMATION	41
5.1. New Provider Enrollment.....	41
Phase ONE - Overview	41
Phase TWO – Orientation (capacity 50).....	41
Phase THREE – Selection of “Setting”	44
Phase FOUR – New Provider Orientation	45
Phase FIVE – Initiation of service to Medicaid Beneficiary	46
Phase SIX – HCBS Settings Rule Compliance (MUST MEET 100% COMPLIANCE)	46
5.2. Temporary Operating Authority (TOA) Process.....	47
5.3. New Provider Enrollment with Alabama Medicaid Agency.....	49
5.4. Validation of Provider HCBS Self-Assessment	50
5.5. Monitoring of Waiver Services.....	52
5.6. Monitoring of Special Staffing.....	54
5.7. Regional Provider Meetings.....	56
5.8. Provider Name Change Process	57
5.9 New Systems Software Releases	59
QUALITY MANAGEMENT.....	60
6.1. Certification Review Process.....	60
6.2. Provider Training and Technical Assistance.....	66
BEHAVIORAL SERVICES	68
7.1. Behavioral Services Procedural Guidelines.....	68
7.2. Special Level of Staffing Restrictions	69
7.3. Comprehensive Support Systems (CSS) Teams.....	71
WAIVER SERVICES	73
8.1. IRBIs.....	73
8.1.a. For DMH and DHR Funded School Aged Children.....	73
8.1.b. Absentee Rates	73
8.2. Housing Specialist Access Request.....	74
8.3. SUPPORTED EMPLOYMENT	75
8.3.1. Discovery Assessment/Profile.....	75
8.3.2. Pre-Vocational Services- Pathway to Employment.....	76
8.3.3. Vocational Rehabilitation.....	77
8.3.4. Individual Supported Employment Services	79
8.3.4.a. Job Developer.....	79
8.3.4.b. Job Coach	80
8.3.5. Supported Employment Small Group	81

8.3.6. Transportation 82
8.3.7. Benefits Planning and Reporting..... 83



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Letter from Associate Commissioner

October 31, 2019

Thank you for your participation in the Alabama Department of Mental Health's Division of Developmental Disabilities (ADMH-DDD), serving individuals with intellectual and developmental disabilities. The development of a service delivery system that is responsive to the needs of people with disabilities is a priority for the ADMH-DDD. Therefore, this first version of the ADMH-DDD provider manual represents the Division's commitment to provide a statewide system, of services and supports, that is efficient and effective.

Alabama Administrative Code regulation 580-5-29.01 sets forth our Division's authority and responsibility to establish reasonable rules, policies, orders and regulations that provide details of carrying out its duties and responsibilities. It is important to note this manual is the ADMH-DDD's first effort to document policies, practices and procedures that were indicated a priority by internal staff to improve on certain practices and to ensure facilitation of the same are in alignment with expectations set forth in this manual across all regions. Although some of the guidelines may directly relate to direct service providers, the manual does not encompass all provider requirements.

As the ADMH-DDD embarks on further improving person centered practices and individual choice of those served, this manual will continue to evolve and be updated to reflect progress towards those efforts.

ADMH-DDD perceives providers and all stakeholders as partners in a common goal to provide quality, person-centered, and cost-effective services, to individuals with intellectual and developmental disabilities so they may live fulfilling and rewarding lives. We look forward to future work around guidelines that include stakeholder engagement and evaluation of the ADMH-DDD service delivery system.

Sincerely,



Terry L. Pezent
Associate Commissioner, ADMH-DDD

CHAPTER 1

ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

1.1. Intake/Information and Referral

Responsible Office: Support Coordination/Call Center

Reference: Settlement Agreement in Susan J., et al, v Bob Riley, et al; Case Management Standard Operational Procedures (SOP), Medicaid Waiver, Administrative Code: CHAPTER 580-5-31

PROGRAM ADMINISTRATIVE STANDARDS; 580-5-31-.14; Consumer Eligibility and Level of Care Determinations for ADMH-MR Medicaid Waiver Programs

Statement: The Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DD) designated a statewide 1-800 Call Center (CC) as the initial point of contact to request Home and Community Based Services (HCBS) as a part of the settlement in the Susan J. vs. the State of Alabama and ADMH-DD.

Purpose/Intent: The CC is the centralized point of contact to initiate and ensure the request of referrals will be expedited. The CC handles hundreds of calls each month from people all over the state as well as across the country seeking information and services. Through a series of questions, the CC staff records each caller's request and determines whether or not the application process should be initiated or if the caller should be directed to another human service agency. For persons who have an intellectual disability, demographic information is taken and referred to the designated Intellectual Disabilities (ID) Support Coordination Agency covering the county of residence of the person in need of service. CC staff discloses and explains the requirements of the waiver programs. The intake information is maintained by a CC staff person for follow-up to ensure timely contact by the Support Coordination Agency (SCA). To access ADMH-DD administered waiver services, all request must come to the CC. Regardless of the location of the caller, the county in which the person resides will dictate the regional office and support coordination agency (SCA) to which the referral will be sent.

Scope: Support Coordination Agency (SCA) and Call Center Staff

Definitions: Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DD); Call Center (CC); Home and Community Based Services (HCBS), Support Coordination Agency (SCA)- formerly referred to as Case Management Agency, Support Coordinator (SC)- formerly referred to as case manager, Division of Developmental Disabilities Information Management System (DDD IMS)

Procedures: Those seeking services for person with intellectual disabilities through the Alabama Department of Mental Health Division of Developmental Disabilities should:

1. Contact the Division of Developmental Disabilities Call Center at 1-800-361-4491.
2. The Call Center staff will complete the initial contact application on referrals for individual's three (3) years of age and up who meet the eligibility requirements and will request the Intellectual Quotient (IQ)(69 and below) of the person in need of services in addition to other pertinent information.
3. CC staff will accept calls from the individual requesting services, the legal guardian, the primary caregiver, or other interested parties who have consent to relay information and who will be responsible with assisting with the referral process.
4. Within two business days, an initial contact form will be sent via a note in DDD IMS to the local designated support coordination agency or other designated point of entry.
5. CC staff will make referrals to the SCA based solely on verbal report of the caller. CC staff will not deny a chance to any caller of receiving services if there is a possibility that the person is eligible for the waiver.
6. The CC staff does not determine eligibility unless the caller states that they or the person for whom they are calling do not have an intellectual disability.
7. CC staff will make a referral to the SCA even if there is no evidence of the person for whom the service is requested is eligible or has Medicaid.

8. The **Initial Contact Information Form** will be sent to the SCA via the DDD IMS notes. This form will have the type of referral checked in the box at the top. There are three options; the first is the *Initial Application Referral* which reflects a first-time applicant requesting services. The second is *Referral for Update* which means there has been a call received from/for someone who already has been referred to the SCA but a Notice of Incomplete Application was sent to the requester. Third is the *Info/Referral only* which is used for persons looking for services outside of ADMH-DD. The same information sent to SCA is sent to the ADMH-DD Regional office Wait List Coordinator. The eligibility determination process continues to be the prerequisite for all categories.
9. CC staff will send a letter to the person calling, verifying the date of call and that their requests have been forwarded to the designated SCA in their area to continue the application process.
10. CC staff will open a DDD IMS enrollment for the person in need of service. It is the responsibility of the SCA to make a change in DDD IMS reflective of the assigned support coordinator from the CC.
11. CC staff will send the application for services on referrals made by Department of Human Resources (DHR) on children or adults in their custody to the DHR, ADMH-DD contact, to the support coordination agency, to the Regional Community Service Director and the Community Service Waitlist Coordinator.
12. If by 30 days after the referral has been received from the Call Center and the SCA has not contacted the person or the documents have not been provided by the caller and/or sent to the regional office, then the CC will contact the SCA. This ensures the SCA has made attempts to contact the person requesting services. The SCA must document their efforts to contact the person or their family in DDD IMS notes. Reasonable efforts to contact the person or family member would be two documented phone calls and a letter.
13. If by 60 days after the referral has been received from the CC and contact has not been made or documents have not been gathered, then an email will be sent by the call center coordinator to the SCA intake person and the waitlist coordinator requesting a follow-up.
14. The SCA must document their efforts to contact the person or their family in the DDD IMS notes. Reasonable efforts to contact the person or family member would be two documented phone calls and a letter.
15. Once contact with the individual seeking services has been established, the SCA will submit the completed information packet for review to the Regional Community Service Office that serves the applicant's county and, if approved, the applicant's name will be placed on the waiting list. ADMH will make a determination of eligibility within 30 days of the receipt of the completed application.

****Exceptional Circumstances: If an individual or their family member has difficulty with communication via the phone, arrangements can be made with the Regional Community Service Office to set up a face-to-face meeting.*

****Exceptional Circumstances: When a military family calls the CC to request services in Alabama, the family will need to email, fax or mail their relocation documents to staff within 30 thirty days of their move.*

1.2. Waiting List

1.2.a. Criteria for Determining Eligibility and Placement on the Waiting List

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-30-.13, Eligibility and Level of Care Determinations for Medicaid Waiver Programs

Statement: Eligibility for Waiver services and placement on the Waiting List will be determined based on verifiable and valid documentation.

Purpose/Intent: The process for determining eligibility for Waiver services and being placed on the Waiting List involves specific, crucial steps governed by detailed standards and practices of communication between the Waiting List Coordinator and the Support Coordination agency.

Scope: Director of Community Programs; Regional Community Services; Support Coordinators

Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); ICAP (Inventory for Client and Agency Planning)

Procedures:

1. The Waiting List Coordinator reviews eligibility documentation in the application packet provided via web-based application by the designated Support Coordination agency, which must include:
 - a. A qualifying psychological evaluation administered/interpreted by a qualified professional on/after the eighteenth birthday (for an adult) or within three years of the date of application (for a child less than eighteen years of age).
 - b. For a person eighteen years of age or older, another qualifying psychological evaluation prior to the eighteenth birthday.
 - c. An ICAP Compuscore report completed within ninety days of the date of a complete application packet.
2. In order for the applicant to be deemed eligible for Waiver services and, thus, placement on the Waiting List, the submitted eligibility documents must unequivocally demonstrate the following:
 - a. The applicant evidences significant problems in at least three adaptive functioning subscales (Self-Care, Receptive & Expressive Language, Mobility, Self-Direction, and Capacity for Independent Living).
 - b. The applicant achieved a full-scale IQ score below 70, with no evaluations documenting a full-scale IQ score of 70 or above on an accepted intellectual assessment. The highest score of any evaluation administered will be the score considered as valid.
 - c. Onset of the applicant's intellectual disability occurred before the age of eighteen.
 - d. The primary cause(s) of impaired functioning or the full-scale IQ less than 70 is not the result of mental illness or external factors such as medication or stress.
3. In the event the application packet does not include any of the documentation listed in 1., above, or does not unequivocally demonstrate that the person meets the eligibility criteria listed in 2., above, the application packet will be considered incomplete, and the Waiting List Coordinator will communicate via DDD IMS to the Support Coordination agency details on which document(s) and/or information (if any) are needed to complete the packet and make a determination on eligibility.
 - a. In the event the needed document(s) and/or information are not submitted within 60 days of the Waiting List Coordinator's DDD IMS notification, the application packet will be deemed incomplete, and the Waiting List Coordinator will send to the applicant a Notice of Incomplete Application (found in the Enrollments record in the DDD IMS). A copy of this notification will be recorded in the DDD IMS.
 - b. If the applicant has conflicting documentation or has an IQ of over 65 or is hospitalized at the time of application or presents with multiple diagnosis. The CSD will request that the application be reviewed by the Behavioral and Psychological Evaluators from at least three Regional Offices, who will provide a written summary of their recommendation of eligibility within 45 days of receipt of request for review.
4. In the event the applicant is deemed ineligible for Waiver services, the Waiting List Coordinator will send to the applicant a Wait List Denial Notification (found in the Enrollments record in the web-based application), which includes full details on appeal rights and processes. A copy of this notification will be recorded in the DDD IMS.

5. When all necessary documents are received and contain the required eligibility information, and within ninety days of the date of a complete application packet, the Waiting List Coordinator reviews the criticality assessment, completed by the Service Coordination agency to ensure:
 - a. All fields are completed fully and accurately.
 - b. Each service group is selected under only one needs Category.
 - c. Substantiating documentation is provided via DDD IMS, if Category 1 (High Risk) is selected for any service group.
6. Once eligibility is positively determined, and the criticality assessment is reviewed and completed, the Waiver Coordinator will designate the person's Wait List record in the DDD IMS as Approved, thus placing them on the Waiting List.
7. Upon approval for the Waiting List, the Waiting List Coordinator will send to the applicant an Initial Eligibility Notification Letter. A copy of this notification will be recorded in the DDD IMS.

1.2.b. Wait List Eligibility Applications from ADMH Inpatient Facilities

Responsible Office: Office of Community Programs, Call Center

Reference: ADMH Administrative Code 580-5-30-.12 (3), Alabama Medicaid Code, Call Center Procedures

Statement: The Alabama Medicaid Agency designates the DMH as the entity authorized to determine individuals' eligibility for participation in the Medicaid Home and Community-Based Services (HCBS) Waiver for persons with Intellectual Disabilities (ID Waiver) and for the Alabama Living at Home Waiver (LAH Waiver). Within the DMH, the oversight and monitoring of day to day operations of the Waiver programs are conducted by the Division of Developmental Disabilities through its Central Office and its Regional Community Service Offices.

Purpose/Intent: To centralize the process of wait list eligibility for ADMH inpatient applicants utilizing the DD Call Center and Regional Community Services Offices as main points of contact to improve efficiency and uniformity in eligibility determinations, statewide.

Scope: These procedures apply to ADMH facility staff, Regional Community Services Offices, and ADMH-DD Call Center.

Definitions: ADMH Inpatient Facilities- Bryce Hospital, Mary Stark Harper Center, Taylor Hardin Secure Medical Facility (THSMF) DDD IMS – Division of Developmental Disabilities Information Management System. This system has previously been known as MRSIS.

Procedures:

1. Patient representative (typically ADMH social worker) initiates call to ADMH-DD Call Center to begin wait list application process for patient currently hospitalized.
2. Intake application information is gathered and entered into DDD IMS by call center staff.
3. Patient representative is routed to appropriate Community Services Office with regard to the patient's region of origin.
4. Application is sent to patient's region of origin Community Services Director and Wait List Coordinator.
5. Patient representative is instructed to submit supporting documents and all other application materials to the Community Services office. All communications needed for completion of application will be facilitated from Regional office to ADMH patient representative.
6. Eligibility determination is rendered by the Regional Community Services Office and standard process of notification is followed.
7. ADMH facilities will adhere to same process for appeals as community applicants.

1.2.c. Waiting List – Entry to Services

Responsible Office: Regional Community Services

Reference: 1915c Home and Community Based Intellectual Disabilities Waivers; Wait List Selection Process, O.G 6.5; Administrative Code 580-5-30-.12 (3)

Statement: Persons on the Waiting List are periodically identified to enter Waiver services.

Purpose/Intent: Entry to Waiver services requires communication between Regional Community Services and Support Coordinators and between Support Coordinators, applicants, and potential providers, as well as verification of eligibility.

Scope: Director of Community Programs; Regional Community Services; Support Coordinators; DDD Central Office

Definitions: RCS (Regional Community Services); MSIQ (Medicaid Database); ICAP (Inventory for Client and Agency Planning); Request for Proposal (RFP); ID (Intellectual Disabilities); LAH (Living at Home)

Procedures:

1. DDD Central Office notifies RCS of those applicants on the Waiting List identified for entry to Waiver services.
2. The Waiting List Coordinator:
 - a. Identifies those applicants specific to their Region approved for Waiver services.
 - b. Sets the Waiting List status of each approved applicant to “Pending” in the web-based application.
 - c. Verifies the Medicaid eligibility for the ID or LAH Waiver of each approved applicant via MSIQ.
 - d. Reviews the Waiver eligibility information submitted at the time of application and, if necessary, requests updated information (including an ICAP score within 60 days) to verify current eligibility.
 - e. Notifies the responsible Support Coordination agency(s), via the web-based application, of each applicant approved for Waiver services, provides the verified Medicaid eligibility information for each, and directs them to serve the identified person(s).
 - f. Circulates to applicable providers the RFP(s) prepared by the Support Coordinator for each applicant identified for entry to Waiver services, allowing 7 business days for providers to respond.
 - g. Adds to the Placement Committee agenda each applicant approved for the Waiver and:
 - i. Reviews documentation in the web-based application and communicates with the Support Coordinator at least biweekly to track and report progress toward entry to Waiver services.
 - ii. Collaborates with the Support Coordinator to troubleshoot and resolve any barriers to entry to Waiver services (e.g., Medicaid ineligibility, inaccurate contact information, non-response to RFP(s)).
3. In the event the Support Coordinator exhausts all available contact options and is unable to make contact with the approved applicant or their caregiver(s) within 10 working days of the first attempt at contact, the Support Coordinator will send to the most recent residential address on record a certified letter requesting immediate response. If there is no response to the certified letter within an additional 10 working days, the applicant’s Waiting List Record will be denoted as “Services Not Needed/Wanted” in each service category (e.g., Residential, Day and Supports). The applicant will remain on the Waiting List with their record closed to Support Coordination in the web-based application.
4. After initial contact with the approved applicant or their caregiver, the Support Coordinator identifies needed Waiver services and initiates the process of choosing providers, preparing and transmitting to the Waiting List Coordinator the RFP, as noted in 2f, above. If the applicant or caregiver does not choose among responding providers within 90 days of this initial contact, the applicant’s Waiting List Record will be denoted as “Services Not Needed/Wanted” in each service category (e.g., Residential, Day and Supports). RCS will notify the applicant of this action by letter.
5. If the Support Coordinator identifies that the needed volume/types of services can be managed within the spending limits of the Living at Home Waiver, this will be the first Waiver offered to the individual as the least restrictive choice.

1.2.d. Wait List Selection Process

Responsible Office: System Management

Reference: ADMH Administrative Code 580-5-30-.12 (3); Waiting List selections for eligible individuals

Statement: A list of names will be selected periodically

Purpose/Intent: To ensure eligible individuals waiting for services are admitted periodically at time frames determined by the ADMH Central Office

Scope: Waitlist for the ID and LAH Waivers

Definitions:

Procedures: Upon notification to the MH Specialist responsible for the submissions of applications to Alabama Medicaid Agency will select the number of individuals for the wait list as instructed by the Director of System Management by:

1. Running the report through the following process
 - a. At the System Home Screen choose the **ID Wait List**
 - b. At **Filters** select work queue that is equal to **“Approved”**
 - c. Select **Rank** as the number instructed by the Director of System Management
 - d. Select **Status** equal to **“Waiting, no services being provided”**
 - e. Click **Search** and the report will be extracted
 - f. Click on **“Alabama ID wait list ranking”** in blue print at the top of the page
 - g. Export the data in desired program format
2. Save and Print the report
3. Send the wait list to all the Community Services Directors at the Regional Offices who will notify the Wait list Coordinator
4. The Wait List Coordinator verifies each individual eligibility is current as well as, the Medicaid status of each. (Reference Kevin’s Policy Number)
5. The Wait List Coordinator enters a note in the DD Information System that alerts the Service Coordinator as to any action, if any, that is needed to begin the initial application process. (Reference Kevin’s Policy #)
6. The Wait list Coordinator will notify the appropriate Support Coordination Agency to begin the initial application process for those individuals identified for initial admission to the waiver
7. The Wait List Coordinator will put the individual’s case in **“pending”** status to ensure the individual’s name is not duplicated on the next wait list selection
8. The MH Specialist II will monitor the initial applications and mark through the names of the individuals processed indicating the application was processed through the Alabama Medicaid Agency’s Long-Term Care software
9. The MH Specialist will contact the Wait List Coordinator periodically to determine the status of those applications not processed
10. The MH Specialist will report to the Director of Systems Management the number of individuals selected for each period and updates on the number of individuals whose applications have not been processed.

1.3. Inventory for Client and Agency Planning (ICAP) for Community Services

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-30.13 Eligibility and Level of Care Determinations for Medicaid Waiver Programs,

Statement: The ICAP is administered by the Support Coordinator to assess adaptive eligibility for the Waiver.

Purpose/Intent: Adaptive eligibility for Waiver services must be established upon application for the Waiver and annually at the point of re-determination.

Scope: Director of Community Programs, Regional Community Services; Support Coordinators; DDD Central Office

Definitions: ICAP (Inventory for Client and Agency Planning); RCS (Regional Community Services); CSS (Comprehensive Support Services)

Procedures:

1. Prior to administering the ICAP, the Support Coordinator will be trained in its administration by the RCS Behavioral and Psychological Evaluator or, in the absence of that position, a member of the CSS Team.
2. The Support Coordinator administers the ICAP:
 - a. Upon referral from ADMH of an applicant for the Waiver, the ICAP administration must occur within 90 days of the application being submitted to the RCS office for eligibility determination.
 - b. At least every two (2) years at the point of re-determination of eligibility.
 - c. Anytime information regarding the person served changes significantly.
3. In completing the ICAP, the administering Support Coordinator is to interview the applicant/person served and/or a caregiver most familiar with the capabilities of the person served (e.g., someone who has close, daily involvement), as indicated. The ICAP protocol is not to be given to a provider or provider employee/staff person to complete on their own.
4. The applicable scores yielded by the ICAP administration are entered into the Eligibility Assessment in the web-based application.
5. For reference, the completed ICAP protocol is scanned and uploaded to the record of the applicant/person served in the web-based application.

1.4. Criticality Assessment

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-30

Statement: The Criticality Assessment is completed by the Support Coordinator and then electronically submitted, via DDD IMS, for approval by Regional Community Services.

Purpose/Intent: The Criticality Assessment was created by the Department of Mental Health to evaluate the urgency of a person's need for services.

Scope: Director of Community Programs; Regional Community Services; Support Coordination

Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); CSD (Community Services Director)

Procedures:

1. The Support Coordinator completes/updates the Criticality Assessment using verifiable information obtained from pertinent documentation and/or interviews with the person applying for Waiver services and/or their caregiver(s).
 - a. Specific substantiating documentation must be obtained and uploaded to DDD IMS Notes if Residential and/or Supports services are selected in Category 1 – High Risk.
2. The Criticality Assessment is to be completed by the Support Coordinator within 90 days prior to the application for Waiver services.
3. The Criticality Assessment is to be updated by the Support Coordinator within three (3) business days anytime they are informed the person on the Waiting List has experienced a substantial change in circumstances and/or needs.
 - a. When the Criticality Assessment is denoted as Complete by the Support Coordination supervisor, the Support Coordinator notifies the Waiting List Coordinator of the updated Criticality via DDD IMS Notes.
4. Upon notification of a New or Updated Criticality Assessment, the Waiting List Coordinator reviews it within three (3) business days and resolves it by denoting it as Approved or by notifying the Support Coordinator, via DDD IMS Notes, of needed corrections or documentation.
5. The Waiting List Coordinator checks the Waiting List tab in DDD IMS weekly for New and Updated Criticality Assessments and resolves each by denoting them as Approved or by notifying the Support Coordinator, via DDD IMS Notes, of needed corrections or documentation.
6. Anytime the Waiting List Coordinator denotes a Criticality Assessment as Approved, they are to immediately set the Wait List Work Queue to Approved, thus ranking the person on the Waiting List according to the new/updated Criticality score.

1.5. Request for Psychological Testing

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-30-.13 Eligibility and Level of Care Determinations for Medicaid Waiver Programs

Statement: The Alabama Medicaid Agency designates the DMH as the entity authorized to determine individuals' eligibility for participation in the Medicaid Home and Community-based (HCBS) Waiver for persons with Intellectual Disabilities (ID Waiver) and for the Alabama Living at Home Waiver (LAH Waiver)

Purpose/Intent: Assist persons who are seeking placement on the Alabama Department of Mental Health Division of Developmental Disabilities Waiver Waiting List with obtaining Psychological Testing to establish eligibility for ID and LAH Waiver services.

Scope: Director of Community Programs; Regional Community Services; Support Coordinators

Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); RFA (Request for Action); ICAP (Inventory for Client and Agency Planning); CSD (Community Services Director); IEP (Individualized Educational Plan); CSS (Comprehensive Support Services); BPE (Behavioral & Psychological Evaluator)

Procedures:

1. The following should be completed, and documentation should be uploaded into DDD IMS by the support coordination agency prior to requesting intelligence testing from the Regional Office:
 - a. Collect educational information such as most recent IEP or other school related records.
 - b. Collect all prior psychological testing results and/or reports.
 - c. If, upon review of the eligibility information submitted, further psychological testing is required to accurately determine eligibility for the Waiting List, all community options for psychological testing must be exhausted.
 - Community options may include, as applicable, school psychometrists, licensed private practitioners, Rehabilitative Services, etc.
 - d. Administer ICAP. Note that, if no intellectual testing results are available prior to age 18, the ICAP may still be administered.
 - e. Collect all relevant and adequate developmental documentation.
2. If no community options for psychological testing are accessible, it is appropriate to request testing from the Regional Office, and the support coordination agency should:
 - a. Submit the Regional Request for Action Form (RFA) to the designated Regional Office. At minimum, the RFA should include:
 - Information concerning prior testing results (either submit in DDD IMS or include in supporting documentation with RFA).
 - A brief explanation as to what community resources were attempted, and the barriers to having the testing completed within the community.
3. When appropriate, the RFA team will approve the RFA and the following steps should be taken:
 - a. The CSD will assign either the Behavioral & Psychological Evaluator (BPE), or consult with the Director of Psychological Services to assign a member of a CSS team, to administer the intelligence test.
 - b. The assigned tester will contact the support coordination agency to schedule a testing date, secure an area for testing with the support coordination agency, and gain any additional information regarding the individual who will be tested.
 - c. The assigned tester will enter test results in DDD IMS and upload psychological report within 10 business days of the test administration. The original psychological report will be filed in the office of the BPE in Regional Community Services.

1.6. Waiver Services

1.6.a. Wait List for Services to Children

Responsible Office: Regional Office

Reference: ADMH Administrative Code 580-5-30-.14; Pursuant to the current DMH/DD policy of the DD Call Center, referrals are accepted on individuals ages 3 and above.

Statement: Referrals of children ages 3 – 21 to DMH/ID/DD are for alternative residential services and / or specialized educational services. A significant number of these referrals are received from the Department of Human Resources (DHR) and the Alabama State Department of Education (ALSDE).

Purpose/Intent: To ensure that adequate and appropriate documentation is secured on all referral of individuals ages 3 – 21, to include any age appropriate psychological assessments, current IEP (including eligibility sheet), medical records, etc. To ensure that all services rendered to children are age appropriate and provided in the least restrictive setting.

Definitions: EPSDT – Early and Periodic Screening, Diagnostic and Treatment Services: Medicaid program benefit providing a comprehensive array of prevention, diagnostic and treatment service for low-income infants, children and adolescents under age 21 as specified in Section 1905(r) of the Social Security Act.

MNC - Multiple Needs Child – a child coming to the attention of the juvenile court who is at imminent risk of out of home placement or placement in a more restrictive environment and whose needs require the services of two or more of the following entities: Department of Youth Services, Department of Human Resources, Department of Education, Department of Mental Health and the Juvenile Probation Office.

IEP – Individualized Educational Plan, FAPE – Free and Appropriate Public Education, LEA – Local Education Agency

Procedures:

1. Referrals of school age children will include a current IEP, inclusive of the Eligibility Page indicating the Special Education classification of said child as well as other age appropriate psychological assessments, medical records, EPSDT results (as applicable) and any other supporting documentation of the child's diagnosis.
2. Upon referral of a child from ALSDE or DHR, verification of Medicaid eligibility and Wait List status will be confirmed. If referred individual is not on the wait list the referral agent will be directed to contact the ID Call Center to initiate the referral process.
3. Documentation of all appropriate resources must have been explored and exhausted prior to individual being placed on the Wait List. If determined eligible, the referred individual will be placed on the wait list. If individual has been deemed a Multiple Needs Child relevant documentation of the MN status should be indicated.
4. If eligibility has been established and individual is currently on Wait List, referral agent will be directed to contact Director of Community Programs to request a waiver slot pending the urgency/criticality of the request.
5. If out of home placement is being requested per DMH Certification standards, placement shall occur in a facility with individuals in the same age range exclusively.
6. If specialized educational services are being requested, i.e. Glenwood or the Learning Tree, documentation of the LEA's inability to provide FAPE is required per ALSDE regulations.
7. If the LEA has indicated that FAPE can be provided, but an alternative residential setting is being requested, an RFP will be distributed to applicable DMH providers by the appropriate Regional Community Services office.

1.6.b. Waiver to Waiver Transfers

Responsible Office: System Management

Reference: Alabama Medicaid Long Term Care Division Policy

Statement: Required Elements for Waiver to Waiver Transfers

Purpose/Intent: To ensure individual health and safety without interruption in service delivery

Scope: All waiver to waiver transfers from or to another operating agency

Definitions: Targeted Case Management (TCM), Alabama Department of Senior Services (ADSS), Alabama Department of Rehabilitation Services (ADRS), Department of Public Health (ADPH)

Procedures:

1. The TCM Support Coordinator should be familiar with the services, eligibility and contact information for the other waiver programs available to individuals served.
2. The TCM Support Coordinator should ensure that eligibility requirements are met to transfer the individual from one waiver to the other.
3. When the individual requests a transfer from one waiver to another waiver, the Support Coordinator should confirm a slot is available on the other waiver by contacting the appropriate state agency's case manager/support coordinator.
4. The transferring case manager/support coordinator should work with the receiving waiver case manager/support coordinator to ensure that waiver to waiver transfer will occur smoothly without a service interruption by working closely with that case manager/support coordinator.
5. The receiving case manager/support coordinator should notify the transferring case manager/support coordinator when all paperwork has been received and the transfer paperwork is all in order.
6. The transferring case manager/support coordinator should close the case on the last working day of the month.
7. The receiving case manager/support coordinator should process the admission to the receiving waiver on the first day of the following month.
8. Waiver services should be authorized to begin on the first day of the month to ensure the individual's health and safety are not compromised.

1.6.c. Termination of Waiver

Responsible Office: System Management

Reference: Medicaid Administrative Code

Statement: Termination of waiver will follow the guidelines outlined by the Alabama Medicaid Agency and standard for all waiver programs

Purpose/Intent: To provide consistency in termination of waiver within established timeframes.

Scope: All waiver terminations

Definitions:

Procedures: Waiver terminations must follow the reasons and timeframes below:

1. Hospitalization-termination one full calendar month of hospitalization.
2. Nursing Home placement-termination after 48 hours of placement
3. Moved out of state-termination after 60 days out of state
4. Death-immediately following notification.
5. No longer meets eligibility requirements-immediate
6. No longer request waiver services-immediate
7. Refusal to adhere to program requirements- 30 days following written notification
8. Transfers to another waiver program-on the last working day of a month.
9. Unable to locate waiver participant-30 days after written notification to last known address remains

without response.

10. Financially ineligible-immediate after notification from the Medicaid District Office.

***Terminations for those participants who are 300% cases must include written notification to the Medicaid District Office.**

1.6.d. Waiver Admission & Discharge

Responsible Office: Regional Community Services

Reference: 1915c Home and Community Based Intellectual Disabilities Waiver

Statement: The Waiver Coordinator completes admission to, and discharge from, the Waiver via the web-based application.

Purpose/Intent: Specific documents, data input, and reporting/recording processes are required to formally admit persons to, or discharge them from, the Waiver.

Scope: Director of Community Programs; Regional Community Services; Support Coordinators; DDD Central Office

Definitions: MSIQ (Medicaid Database); LTC-2 (Notice of HP Enrollment or Termination Action Regarding One of the Home and Community-Based Waiver Program); POC (Plan of Care)

Procedures:

1. When a person is either admitted to, or discharged from, the Waiver, the Waiver Coordinator:
 - a. Prints the most recent Plan of Care and, if a discharge, the LTC-2 form (both previously uploaded by the responsible Support Coordinator) from the web-based application.
 - b. Selects the most recent Waiver Record in the web-based application and:
 - i. Sets the CM Action to "Application/Discharge/Re-Admission".
 - ii. If an admission, sets the CM Action date to that of the POC.
 - iii. If a discharge, sets the CM Action date to that of the LTC-2.
 - iv. If a discharge, sets the Discharge Reason commensurate with the information on the LTC-2.
 - v. Sets the RO Action to "Approved".
 - vi. Sets the RO Action date to the current date.
 - c. Completes a new RO Waiver Registration in the web-based application.
 - i. Sets Consumer Assessments Review to "Discharge/Application/Readmission".
 - ii. Completes other fields in the RO Waiver Registration as appropriate for admission or discharge.
 - iii. Prints the RO Waiver Registration Face Sheet.
 - d. Scans and emails to the Mental Health Specialist II in DDD Central Office:
 - i. RO Waiver Registration Face Sheet
 - ii. MSIQ Screen
 - iii. If a discharge, the LTC-2 form
2. The Mental Health Specialist II forwards the RO Waiver Registration and MSIQ Screen to Medicaid for approval.
 - a. Upon approval, individual waiver segments are added in the **Programs** tab in the web-based application, as applicable.
 - b. The Regional Administrative Assistant files the RO Waiver Registration, MSIQ Screen, and, if a discharge, the LTC-2 form and POC.

CHAPTER 2

INDIVIDUAL RIGHTS

2.1. Appeals

2.1.a. Waiver/Wait List Eligibility Appeals

Responsible Office: Office of Community Programs, Support Coordination, currently Office of PBS

Reference: Alabama Administrative Code, Alabama Medicaid Administrative Code

Statement: The Alabama Department of Mental Health (ADMH) is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community-based services (HCBS) in accordance with the provisions of the Home and Community-Based Waiver for Persons with Intellectual Disabilities.

Purpose/Intent: The process of appeals is one in which cases are reviewed, where HCBS waiver applicants and related parties request a formal change to an official decision. Appeals function both as a process for error correction as well as a process of clarifying and interpreting the criteria and standards by which the original decision was rendered.

Scope: Applicants for the ADMH HCBS Waiver/Wait List, and ADMH-DD staff that are responsible for eligibility determinations.

Definitions: Appeal- a formal request that a decision, as in a legal or official one, be changed.

Procedures:

- 1 If the applicant is determined ineligible, the applicant will receive a memorandum regarding denial of eligibility. This notification will state that the application has been denied specifying the reason (it will describe the statutory and/or regulatory requirement that has not been met).
- 2 The appeal process begins with a written request from the applicant, either to the Division of Developmental Disabilities or to the Alabama Medicaid Agency, with specific timelines involved for each. If the applicant appeals first to the Division of Developmental Disabilities within 15 days of receipt of denial letter, he or she will be entitled to a review by the Associate Commissioner, who will produce a written determination. If the individual is dissatisfied with that determination, he/she has the right to appeal to the Alabama Medicaid Agency within 60 days of notice of action. The notification fully explains the process of appeal to both agencies.
- 3 An individual who is denied Home and Community-Based Services based on Rule No. 560-X-35-.03, may request a fair hearing in accordance with 42. C.F.R. 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code.
 - a. Recipients will be notified in writing at least ten days prior to termination of service.
 - b. A written request for a hearing must be filed within sixty days following notice of action with which an individual is dissatisfied.

2.1.b. Appeals Process for Adverse Actions- Services Decisions

Responsible Office: System Management

Reference: 42-CFR 431.210 (Subpart E); 560-X-3 Medicaid Administrative Code; Appendix F ID and LAH Waivers

Statement: ADMH/DD Division provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are denied the service(s) of their choice or the provider(s) of their choice; or, (b) whose services are denied, suspended, reduced or terminated. ADMH/DD Division provides notice of action as required in 42 CFR §431.210.

Purpose/Intent: Compliance with Federal Regulations regarding individual adverse actions

Scope: Service requests denied, suspended, reduced or terminated

Definitions: RFA (Request for Action), CSD (Community Services Director)

Procedures: The DD Division will adhere to the following steps in appeals requested regarding any adverse action taken by the regional office.

1. Written advanced notification to the individual or responsible person must include:
 - a. Date of Notice
 - b. The specific adverse action being taken
 - c. Specific information about the reason(s) for the adverse action
 - d. The effective date of the action
 - e. The individual's right to request an informal conference or fair hearing with Alabama Medicaid and the procedures for doing so
 - f. Notice that an informal conference is not an alternative to a fair hearing
 - g. If the individual requests the informal conference or fair hearing within ten (10) days of receiving the notice of adverse action, service involved will continue at the current level according to the plan of care until the appeal process has been exhausted. Services requested, denied and/or not currently on the plan of care will not be provided during the appeal process.
 - h. Point of contact if there are questions regarding the action
2. The written request from the individual receiving notification of any adverse action will be sent to the Associate Commissioner of the DD Division.
The Associate Commissioner will choose a panel of three members to review the denied RFA.
3. The three-member panel will consist of a CSD from another regional office and two persons within the DD Division employed at the Central Office.
4. The panel will review the denied RFA and other information individually making note of any questions that may arise and complete the Review of Denial Form.
5. A teleconference will be scheduled with the 1) participant/family/guardian/representative, 2) panel, 3) CSD responsible for approving/denying RFA's in the participant's Region, 4) Program Administrator for AMA/LTC ID/LAH Waiver (if warranted) and 5) participant's support coordinator.
6. The teleconference will provide the participant/family/guardians time to offer any information to the panel that may change the outcome of the RFA decision. The panel will also utilize the time to ask any specific questions to either the participant/family/guardians, the CSD or the support coordinator that may be needed to provide more clarity and indicate responses on the Review of Denial Form.
7. Following the teleconference, the panel will make recommendations in writing to the Associate Commissioner of the DD Division to reverse or uphold the original decision made by the CSD through completion and submission of the Review of Denial Form.
8. The Associate Commissioner will notify the participant/family/guardian of the decision in writing.
Due process appeal procedures will be included with the response from the Associate Commissioner in the event the participant/family/guardian remains in disagreement with instructions on how to request a fair hearing.



KAY IVEY
Governor

Alabama Medicaid Agency

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P.O. Box 5624
Montgomery, Alabama 36103-5624
www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov

Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504



STEPHANIE MCGEE AZAR
Commissioner

NOTICE OF APPEAL RIGHTS

If an individual/guardian chooses to appeal an adverse decision, they may choose to appeal first to the Alabama Department of Mental Health (ADMH), and if not satisfied with the decision rendered in that appeal, may then further appeal to the Alabama Medicaid Agency (Medicaid). Or, they may appeal first directly to Medicaid.

1. REQUEST AN APPEAL TO THE ALABAMA DEPARTMENT OF MENTAL HEALTH

To appeal first to the ADMH/Associate Commissioner for the Division of Developmental Disabilities. A written request for an appeal must be received by the Associate Commissioner for Intellectual Disabilities no later than 15 calendar days after the effective date printed on the Notice of Action. A written decision from the Associate Commissioner will be mailed (certified) to the individual/guardian within 21 days after the review of all information. If the individual/guardian disagrees with the Associate Commissioner's decision, he/she can request a Fair Hearing to the Medicaid. A written hearing request must be received by Medicaid no later than 15 calendar days from the date of the Associate Commissioner's letter.

2. REQUEST AN APPEAL/ FAIR HEARING TO THE ALABAMA MEDICAID AGENCY

If the individual/guardian chooses to first appeal to the Alabama Medicaid Agency, a written request asking for a fair hearing must be received by Medicaid within 60 days from the date the Notice of Action is mailed. The individual/ legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for a hearing is made by someone other than the person who wishes to appeal, the representative must make a definite statement that he has been authorized to do so by the persons for whom the hearing is being requested. Information about hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the persons will be arranged. If the person is satisfied before the hearing and wants to withdraw his request, he or his legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he wishes to do so and give the reason for withdrawing.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy, which requires an automatic change adversely affecting some or all recipients. When benefits are terminated, they can be continued if a hearing request is received within ten (10) days after the effective date of Notice of Action, unless there are unnecessary delays by the person requesting the hearing for this representative. If benefits are continued pending the outcome of the hearing and the Hearing Officer decided that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

MEDICAID ELIGIBILITY DIVISION POLICIES AND PROCEDURES ARE IN COMPLIANCE WITH THE CIVIL RIGHTS ACT OF 1964 AND SECTION 504 OF THE REHABILITATION ACT OF 1973

Send written requests for reviews and fair hearings to:

ALABAMA MEDICAID AGENCY
Long Term Care Division
P.O. Box 5624, 501 Dexter Avenue
Montgomery, AL 36103-5624

I have reviewed and been given a copy of my right to a Medicaid review of the case and/or a Fair Hearing.

Signature of Recipient or Legal Representative

Date

Print Recipient's Name

Witness Signature and Date

2.2. Dissatisfaction of Services

Responsible Office: Support Coordination

Reference: 42 CFR 441.302(d). ID and LAH HCBS Waivers

Statement: Persons enrolled in one of the Alabama Medicaid Home and Community Based Waiver programs for people with intellectual disabilities will receive written notification of their rights to a review of their case and/or a fair hearing if they are dissatisfied with the services he/she is receiving.

Purpose/Intent: The Dissatisfaction of Services form is a disclosure required by Alabama Medicaid to ensure a person enrolling or already receiving HCBS waiver services and their legally authorized representative are aware that they have the right to due process should they become dissatisfied with Medicaid funded services.

Scope: Applies to a person who is dissatisfied with his/her services under the Medicaid Home and Community-Based Waiver (Living at Home Waiver or Waiver for Persons with Intellectual Disabilities); A Legal Representative for a person who receives services under a Home and Community-Based Waiver; Support Coordinators

Definitions: People – HCBS Waiver participants; Support Coordinators – Formerly referred to as Case Managers; Regional Community Services Office staff – One of five regional offices located throughout the state; Due Process – Medicaid review of the case/complaint and/or a Fair Hearing; HCBS – Home and Community-Based Services

Procedures:

1. The Dissatisfaction of Services form must be completed at the time a person is admitted to Medicaid HCBS Waiver Services. It may be completed more frequently, i.e. annually, when a person changes waivers or services.
2. A person who is dissatisfied with his/her services under the Medicaid Home and Community-Based Waiver program (Living at Home Waiver or Waiver for Persons with Intellectual Disabilities) may notify the Alabama Medicaid Agency giving the reason for the dissatisfaction and ask for either a conference or a review of the case by the Alabama Medicaid Agency. At the conference, the person may present the information or may be represented by a friend, relative, attorney or other spokesperson of their choice.
3. A written request for a hearing must be filed within sixty (60) days following the action with which the person is dissatisfied. He/she, his/her legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for a hearing is made by someone other than the person who wishes to appeal, the representative must make a definite statement that he has been authorized to do so by the persons for whom the hearing is being requested. Information about hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the persons will be arranged. If the person is satisfied before the hearing and wants to withdraw his/her request, he/she or his/her legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he/she wishes to do so and give the reason for withdrawing.
4. The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy, which requires an automatic change adversely affecting some or all recipients. When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination, unless there are unnecessary delays by the person requesting the hearing for this representative. If benefits are continued pending the outcome of the hearing and the Hearing Officer decided that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.
5. Written request for reviews and fair hearings should be sent to: Alabama Medicaid Agency, Long Term Care Division, P.O. Box 5624, 501 Dexter Avenue, Montgomery, AL 36103-5624.



KAY IVEY
Governor

Alabama Medicaid Agency

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STEPHANIE MCGEE AZAR
Commissioner

DISSATISFACTION OF SERVICES

You are in the process of being enrolled in one of the Medicaid Home and Community-Based Waiver programs for individuals with intellectual disabilities. This is notification of your rights to a review of your case and/or a fair hearing.

1. REQUEST CONFERENCE OR REVIEW OF CASE

A person who is dissatisfied with his/her services under the Medicaid Home and Community-Based Waiver program (Living at Home Waiver or Waiver for Persons with Mental Retardation) may notify the Alabama Medicaid Agency giving the reason for the dissatisfaction and ask for either a conference or a review of the case by the Alabama Medicaid Agency. At the conference, the person may present the information or may

2. REQUEST A FAIR HEARING

A written request for a hearing must be filed within sixty (60) days following the action with which the person is dissatisfied. He, his legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for a hearing is made by someone other than the person who wishes to appeal, the representative must make a definite statement that he has been authorized to do so by the persons for whom the hearing is being requested. Information about hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the persons will be arranged. If the person is satisfied before the hearing and wants to withdraw his request, he or his legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he wishes to do so and give the reason for withdrawing.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy, which requires an automatic change adversely affecting some or all recipients. When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination, unless there are unnecessary delays by the person requesting the hearing for this representative. If benefits are continued pending the outcome of the hearing and the Hearing Officer decided that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

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I have reviewed and been given a copy of my right to a Medicaid review of the case and/or a Fair Hearing.

Signature of Recipient or Legal Representative

Date

Print Recipient's Name

Witness Signature and Date

2.3. Informal Conference- Services

Responsible Office: System Management

Reference: 42CFR-431.200; ID Waiver; LAH Waiver; Medicaid Administrative Code

Statement: People receiving Waver Services will be provided appeal rights regarding decisions by the Operating Agency that adversely affects service provision.

Purpose/Intent: To ensure rights of waiver participants

Scope: Applicable to all waiver services; Regional Community Services Offices, Support Coordination agencies, families

Definitions: Adverse action means any decision that negatively impacts the waiver participant. This includes denials, reductions, delays in, or termination of any waiver service.

Procedures:

1. The Regional office denies the participant's request for service.
2. Responds in writing notifying the waiver participant of the decision and why the decision was made. Letters should include the effective date of the action and must also provide the participant his right to appeal the decision and the steps involved.
3. The waiver participant has 60 days to request an appeal. In the case of termination or reduction of services, the person must request the appeal within 10 days (working or calendar) of notification from the ADMH Regional Office. If received within the 10-day timeframe, service will continue at the current level until the appeal process has been exhausted.
4. Upon request of an informal conference to the ADMH/DD Associate Commissioner will schedule within 15 working days of receipt of the request.
 - a. The Associate Commissioner will choose a panel of three members to review the denied RFA.
 - b. The three-member panel will consist of a CSD from another regional office and two persons within the DD Division employed at the Central Office.
 - c. The Associate Commissioner sets a date for the informal conference within 15 working days of the receipt of the request for informal conference.
 - d. The panel will review the denied RFRA and other information individually making note of any questions that may arise and complete the Review of Denial Form.
 - e. A teleconference will be scheduled with the 1) participant/family/guardian/representative, 2) the panel, 3) the CSD responsible for approving/denying RFRA's in the participant's Region, 4) the Program Administrator for AMA/LTC ID/LAH Waiver (if warranted) and 5) the participant's case manager.
 - f. The teleconference will provide the participant/family/guardians time to offer any information to the panel that may change the outcome of the RFA decision. The panel will also utilize the time to ask any specific questions to either the participant/family/guardians the CSD, or the case manager that may be needed to provide more clarity and indicate responses on the Review of Denial Form.
 - g. Following the teleconference, the panel will make recommendations in writing to the Associate Commissioner of the DD Division to reverse or uphold the original decision made by the CSD through completion and submission of the Review of Denial Form.
 - h. The Associate Commissioner will notify the participant/family/guardian in writing of the decision in writing of the decision within 15 working days of the informal conference.
 - i. Due process appeal procedures to request a Medicaid Fair Hearing will be included with the response from the Associate Commissioner in the event the participant/family/guardian remains in disagreement.

2.4 Other

2.4.1 Forensic Cases

Responsible Office: Office of PBS, Forensic Outpatient program

Reference: ADMH Administrative Code, Alabama Psychological Association, ADMH Legal standard

Statement: In the case of *Atkins v. Virginia* (2002), the United States Supreme Court effectively prohibited the execution of persons with intellectual disabilities by deciding that doing so violated the Eighth Amendment ban on cruel and unusual punishment. People with intellectual disabilities frequently know the difference between right and wrong but, by definition, they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand others' reactions. Their deficiencies do not warrant an exemption from criminal sanctions but diminish their personal culpability.

Purpose/Intent: The Alabama Department of Mental Health may be so ordered by the circuit court of Alabama to facilitate the process for and conduct an Atkins Evaluation for an individual. A certified forensic examiner (as defined and credentialed by ADMH) and/or licensed expert in the field of intellectual and developmental disabilities must complete this evaluation.

Scope: ADMH legal staff and ADMH-DD administration who may receive and respond to court orders for Atkins Evaluation.

Definitions: Atkins- In 2002, the United States Supreme Court held in *Atkins v. Virginia* that the execution of persons with intellectual disabilities is unconstitutional because it violates the Eighth Amendment's prohibition against cruel and unusual punishments. The evaluation examines a person's culpability with regard to their intellectual ability and disabilities.

Procedures:

1. A court order for an Atkins (forensic) evaluation is received and processed first by ADMH legal department.
2. The Forensic Outpatient program coordinator receives the order from legal and facilitates assignments to a DMH contract forensic examiner in the community to complete evaluation.
3. In some cases, the Director of Psychological and Behavioral Services may be assigned the court ordered evaluation to complete, granted it does not pose ethical conflicts.
4. Coordination of date, time, location of test session will be coordinated through the Forensic Outpatient program and/or Regional Community Services Director, and assigned evaluator.
5. Once evaluation is complete, final report is submitted to the Forensic Outpatient Program coordinator.
6. Evaluator may be asked to appear in court and provide testimony related to the Atkins evaluation report submitted.

CHAPTER 3

INDIVIDUAL SUPPORT PLANNING AND IMPLEMENTATION

3.1. Plan of Care

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-30-.12 (7); 1915 Home and Community Based Intellectual Disabilities Waiver

Statement: The Plan of Care outlines specific services requested by the individual and/or family, to be implemented by their chosen service provider.

Purpose/Intent: The Plan of Care enables authorization of services (i.e. volume, frequency, and start date) and provides a current record of the services authorized for a person.

Scope: Director of Community Programs, Regional Community Services, Support Coordinators, Providers

Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); RFA (Request for Action); CSD (Community Services Director); POC (Plan of Care); RCS (Regional Community Services)

Procedures:

1. The Plan of Care (POC) is generated/updated by the Support Coordinator whenever a new service, or a change in services, is approved by RCS or otherwise enacted via the Request for Action policy.
2. The Support Coordinator generates the POC via the **Plan of Care** tab in DDD IMS and:
 - a. Records the Begin date of the POC as the date of the annual Person-Centered Planning Meeting.
 - b. Inputs each service chosen and approved, as applicable, including the provider of each service, using the Act Codes to indicate services added or stopped at the time of the present POC.
 - c. Records the Start Date of individual services as the date of RFA approval by RCS or, if RCS approval is not required, the date the Plan of Care is modified.
 - d. Records the End date of the POC and of individual services as one year from the Begin/Start date.
 - e. Obtains the necessary signatures indicated on the POC.
3. The Support Coordinator uploads the POC to the **Notes** tab of DDD IMS and:
 - a. Tags the Waiver Coordinator as a Note Recipient on the Note to which the POC is attached.
4. The Waiver Coordinator:
 - a. Reviews the POC to verify that it is completed correctly, noting any needed changes to the Support Coordinator via DDD IMS Notes.
 - b. Selects the Note as “Complete” upon verification of POC accuracy, then tags the Fiscal Officer and Support Coordinator as Note Recipients.
5. The Fiscal Officer authorizes services in DDD IMS as indicated on the POC.

CHAPTER 4

SUPPORT COORDINATION AND CASE MANAGEMENT

4.1. Funding for Support Coordination Agencies

Responsible Office: Administrative and Fiscal Operations

Reference: N/A

Statement: Setting amounts for funding support coordination in the Department of Mental Health DD Division

Purpose/Intent: To establish a methodology to determine the amount of budget for support coordination to be provided to contracting agencies during the fiscal year.

Scope: This guideline applies to fiscal managers of the Department of Mental Health DD Division

Definitions: Support Coordination agencies were formerly referred to as Case Management agencies

Procedures: Each year when preparing the operations plan for the upcoming fiscal year regional fiscal managers will run the Units of Service Summary report or equivalent through the Department's web-based billing system. Days specified in the report will be 9/1 of the prior calendar year through 5/31 of the current calendar year. This report will identify the number of distinct individuals served by each program in that time period. Fiscal managers will use that number to calculate the number of dollars to contract with the agency by multiplying the number of distinct individuals identified by the number of currently allocated hours and the current support coordination dollar rate.

During the fiscal year a full allotment of annual hours will be added to the budget of the contracting agency for each new person receiving their services. The full allotment of hours will be added regardless of when in the fiscal year the person begins services.

4.2. Request for Action/Services

Responsible Office: System Management

Reference: ADMH/DDD Operational Procedures

Statement: Following a team meeting where all appropriate persons attend, ADMH/DDD requires the support coordinator to submit the **REQUEST FOR ACTION** (RFA) form to the Regional Office Community Service Director or Designee for any addition to a Plan of Care for the following services. The Regional Office should make the determination within no more than **seven (7) working days** to expedite service delivery.

Purpose/Intent: To expedite the RFA process

Scope: Regional Offices, Support Coordination Agencies, Providers, Central Office

Definitions: RFA (Request for Action) - Additions to an individual's plan of care; DDD IMS (Division of Developmental Disabilities Information Management System)

PROCEDURES FOR SUPPORT COORDINATOR

1. Hold a team meeting of appropriate persons; obtain signatures on revised plan of care.
2. Check Medicaid State Plan Services (SPS) and other insurance to ensure an item is not covered
3. Obtain required supporting documentation as necessary (prescriptions, medical documentation, quote, ICAP, etc.)
4. Complete the RFA Form
5. Submit the RFA Form to the Regional Office electronically through DDD IMS
 - a. Include medical documentation
 - b. Quote for service
6. Add service to the plan of care using the following format:
 - a. Provider Name
 - b. Service Code
 - c. Service Name
 - d. Unit
 - e. Unit Type
 - f. Start Date (start date empty for all services except for hospital/nursing home discharges. Start date will be written as the date of discharge. For all other services, the blank fields indicate the date is pending)
 - g. End Date (start date empty for all services, until approved by the CSD)
7. Submit RFA form to the Regional Office through DDD IMS

PROCEDURES FOR REGIONAL OFFICE

1. Verify all information is included on the RFA. If not, return to support coordinator with a note in the **NEEDED INFORMATION** section of the form. Include the date returned to the support coordinator.
2. Verify the documentation supports the need for service
3. Approved; generate letter to the participant with a copy to the Support coordinator
4. Denied; generate letter to the participant accompanied by appeal rights with a copy to the Support coordinator
5. Sign and date the form
6. Mail original letter to participant and copy support coordinator (upload in DDD IMS) and copy the Executive Director of the support coordination agency
7. Copy to Fiscal Officer in the Regional Office to authorize service through DDD IMS

Once returned to the support coordinator, the support coordinator will:

- a. Add the dates of service to the Plan of Care (*the start date for all services except Specialized Staffing is the date the RFA is approved by the regional office. The start date for Specialized Staffing is the date the participant is discharged from the hospital or nursing home and medical updates document the need) Unless documented, Specialized staffing **should be dated** through the end of the fiscal year. **Provider documentation must support the need for ongoing services at the same level.**
- b. Notify the provider to begin service

****The provider must submit to the regional office CSD information that all staff providing Specialized Staffing, either medical and/or behavior, has met the training requirements as outlined in the waiver document. When changes in staff occur, the provider must submit to the Regional Office that the new employee has been trained and is qualified to provide the service as outlined in the waiver documents.***

Statement:

An RFA ***is not*** required in the following situations. A team meeting ***is not*** required in these instances. The process should be ***completed*** in no less than five (5) days to ensure timely delivery of services:

1. Unit currently authorized and on the Plan of Care that require a change.
2. Service documented as an anticipated service in the participant’s Person-Centered Plan.

All address changes in residential providers or provider sites. The provider is required to submit a new IRBI to the support coordinator who will forward to the Regional Office.

3. Change in providers.
4. Conversions to self-directed services.

PROCEDURES FOR SUPPORT COORDINATOR

Ensure documentation is evident in the Person-Centered Plan or is **on the Plan of Care and authorized.**

1. Make changes to the participant’s Plan of Care
 - a. include the End Date for the previous units and begin date for the new services
 - b. place new service on the participant’s plan of care including start and end date using the same format as above
2. Submit note into DDD IMS with copy to the Waiver Coordinator marked ***Alert***.
3. Waiver Coordinator will verify the Plan of Care has been updated; if not, return to support coordinator to correct.
4. Once approved by Waiver Coordinator, mark the note as ***Complete*** copying the support coordinator and the Fiscal Officer.
5. The Fiscal Officer authorizes the service.
6. Support coordinator will notify the provider of the start date of service.

4.3. Redetermination

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-30.13 (2) (d) Level of Care Determination for Medicaid Waiver Programs, 1915c Home and Community Based Intellectual Disabilities Waiver

Statement: Redetermination of Waiver eligibility is conducted annually, utilizing new and updated documentation of eligibility data.

Purpose/Intent: The redetermination process is implemented annually to ensure continued eligibility for Waiver services and to verify that services identified as needed are being provided appropriately.

Scope: Director of Community Programs, Regional Community Services; Support Coordinators; DDD Central Office

Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); ICAP (Inventory for Client and Agency Planning); LOC (Level of Care); MSIQ (Medicaid Database)

Procedures:

1. The Waiver Coordinator:

1. Downloads the Redeterminations Due Report for the month at hand from DDD IMS, via the **Reports** tab (select Type: MR Clinical).
 2. Reviews supporting documentation uploaded to the DDD IMS **Notes** tab by the Support Coordinator:
 - (1) Signed Plan of Care
 - (2) Dissatisfaction of Services
 - (3) Freedom of Choice
 - (4) Social Summary/Individual Family History
 - (5) Physical or RN Assessment (only until physical is obtained)
 - (6) ICAP
 - (7) Psychological
 3. Prints the Level of Care (LOC) form from the **Demographics** tab.
 - i. Ensures eligibility is evidenced by at least 3 areas of life activity checked on the LOC.
 4. Prints the person's MSIQ screen and checks the **Fund Eligibility** to verify active status for Medicaid.
 5. Reviews the Waiver documents in the **Clients** tab of DDD IMS [referenced tabs are in bold below]:
 - i. Opens the **Diagnosis** tab to ensure information there is consistent with the IQ level on the Level of Care (LOC)
 - ii. Reviews the Eligibility Assessment under the **Assessments** tab (Psychological/ICAP/ABS)
 - (1) Ensures it was completed within 60 days of the redetermination date.
 - (2) Ensures the referenced IQ score is less than 70.
 - (3) Ensures the referenced ICAP was completed within 2 years and review at least annually.
 - (4) Ensures the referenced ICAP score is less than 85.
 - iii. Reviews the Summary of Habilitation record in **Assessments** to ensure the LOC limitations match identified deficits.
 - iv. Reviews the **Plan of Care** to ensure the redetermination/initialed field is marked as "Yes" and to ensure Waiver services provided match those represented in **Authorizations**.
2. If missing or incorrect information is noted during the redetermination process, or if new information suggests eligibility is in question, the Waiver Coordinator documents such in the **Notes** tab and tags the responsible Support Coordinator and their supervisor for follow-up.
3. If all is correct and eligibility remains evident, the Waiver Coordinator:
1. Duplicates the previous year's RO Waiver Registration in the **Assessments** tab, updating for the current date and denoting as "Complete".
 2. Enters the Waiver record in the **Programs** tab and sets the RO Action to "Approved".
 3. Signs and dates the LOC.
 4. Scans and emails to the Mental Health Specialist II in DDD Central Office:
 - i. RO Waiver Registration
 - ii. MSIQ Screen

5. Scans and uploads LOC documents to the Notes tab in individual records in DDD IMS, tagging the responsible Support Coordinator.
4. The Mental Health Specialist II forwards the RO Waiver Registration and MSIQ Screen to Medicaid for approval.
 1. Upon approval, individual waiver segments are added in the **Programs** tab in DDD IMS.
5. The Regional Administrative Assistant:
 1. Prints the LTC-2.
 2. Files the RO Waiver Registration, MSIQ Screen, LOC, and LTC-2.
6. If the ICAP score is in need of change from previous administration, the waiver coordinator will notify the Fiscal Manager.

4.4. Summary Program of Habilitation

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-30.13 (2) (d) 2 Level of Care Determination for Medicaid Waiver Programs, DDD IMS User Guide

Statement: The Summary Program of Habilitation is a digital form accessible in the Assessments tab of DDD IMS.

Purpose/Intent: The Summary Program of Habilitation utilizes information collected via standard assessments to identify the assets, deficits, and maladaptive behaviors of the person, so as to establish an initial habilitation plan.

Scope: Director of Community Programs; Regional Community Services; Support Coordinators

Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); ICAP (Inventory for Client and Agency Planning); LOC (Level of Care form)

Procedures:

1. The Support Coordinator completes the Summary Program of Habilitation at the time of intake to Waiver services and annually as redetermination information is prepared (at least 30 days prior to the person's redetermination date).
 - a. The following fields are auto-populated directly from information on the LOC:
 - i. AAMR Defined Measured Intellectual Level
 - ii. Adaptive Behavior Level
 - b. Assets must reflect skills the person can perform independently.
 - c. Deficits must reflect the areas identified as limitations on the LOC, with added specificity.
 - d. Maladaptive behaviors must reflect documented behaviors that are harmful to the person and/or others or otherwise interfere with daily functioning.
 - e. The Initial Habilitation Plan must include goals for training to improve each of the identified skill deficits.
2. The Waiver Coordinator reviews the Summary Program of Habilitation during the redetermination process to ensure that the information therein is consistent with that reported on the LOC.

4.5. Monitoring - Individual Experience Assessment Survey

Responsible Office: Support Coordination

Reference: 2014 HCBS Rule

Statement: The Home and Community Based Settings (HCBS) Rule that went into effect March 17, 2014, set forth by The Centers for Medicare and Medicaid Services (CMS,) requires that states review and evaluate the quality of HCBS supports and services experienced by persons receiving these services. Upon initiation of waiver supports and services AND at least annually thereafter, the Support Coordinator shall assess each person's experience in receiving Medicaid HCBS waiver services.

Purpose/Intent: The purpose of this guideline is to specify the State's procedures and timelines for assessing and measuring each person's level of awareness of and access to exercising their rights, privacy requirements and life experiences in their day-to-day activities while living in their communities. The survey results will be used to assess changes that may be needed to improve the experience people have when receiving Home and Community Based Services. This survey will also help ensure Alabama is compliant with the HCBS Settings Rule.

Scope: Support Coordinators, people determined to require a level of care for the ID, LAH and future waivers administered by the DMH DDD, Regional Community Services (RCS) Monitors and Support Coordination Liaisons

Definitions: People – HCBS Waiver participants; Support Coordinators – Formerly referred to as Case Managers, employed by 310 Boards; ID waiver – Intellectual Disabilities waiver; LAH waiver – Living-at-Home waiver

Procedures:

1. Support Coordinators shall assess people moving into **NEW settings within 5 days before or after day 60 of enrollment in waiver services and/or move into the new setting**. This assessment should be coordinated with the Regional Office's validation Report of 100% compliance with the 2014 HCBS Settings Rule by the assigned Monitor in the same time-frame.
2. For persons currently receiving Medicaid Waiver services, the initial IEA will be completed at the time of their first annual PCP assessment/meeting scheduled after the May 1, 2019 implementation date, and annually thereafter.
3. Participants in the IEA shall include the person and his or her family members and/or representative, as appropriate. The person's input should be obtained first, with input from others involved used when the person is not able to respond to one or more of the questions independently. Service provider staff may participate as requested by the individual and his or her family and/or representative.
4. Results are submitted to the provider and the Regional Office Monitor within at least TEN (10) business days of the date the survey was completed. [Original to the Regional Office Monitor, copies to the provider agency(s), Support Coordination Liaisons and Support Coordinator].
5. Follow up on any area NOT in Compliance shall be completed within TEN business days of date of survey. Follow up may consist of revision of the PCP by the Support Coordinator or remediation by the provider with completion verified by the Regional Office Monitor and Support Coordination Liaisons.
6. The person's Support Coordinator, as applicable, shall address any issues regarding compliance with the HCBS Settings Rule or other concerns identified during the IEA. Each **NO** response should be investigated to determine if it is appropriately supported by the PCP or if it is truly **Not in Compliance**. Specific remediation should occur for any response that is determined to be **Not in Compliance**.
7. Initial surveys (original) should be forwarded to the Regional Office Monitors and Support Coordination Liaisons. Thereafter, only surveys reflecting non-compliance should be forwarded to Regional Office Monitors and Support Coordination Liaisons. Provider agency(s) shall receive copies of initial and annual assessments.

NOTE: If Personal Care Supports/Services are provided to a person in a setting that is NOT provider owned or operated (i.e. their own apartment/home, family home or they reside with someone considered a natural support), a response of **NO in Section E does not automatically indicate Not in Compliance**.

ADMH – Division of Developmental Disabilities	Individual Experience Assessment Survey (IEA)
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Section A: General Information - A response to each question is required unless otherwise indicated.

1. Person’s First and Last Name:	Date of Survey:
2. Does the person have a legal guardian? If no, skip to question 4. If yes, answer 3a – 3b A guardian is a person appointed by the probate court to oversee the personal and/or financial affairs of an adult who is determined to be incapable of managing his or her own affairs or unable to care for himself or herself.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. If yes, is the guardian a paid/corporate guardian (i.e., the guardian is an attorney or works for an agency), or an unpaid family/friend?	<input type="checkbox"/> Paid Guardian <input type="checkbox"/> Unpaid Guardian
a. If Unpaid Guardian, enter the name of the Guardian	
b. If Paid Guardian, Enter the name of the Guardian/ Agency	
4. In which Waiver is person enrolled (select one): <input type="checkbox"/> ID Waiver <input type="checkbox"/> LAH Waiver	
Name of Support Coordinator Conducting IEA:	
Support Coordinator employed by:	
5. Number of months SC has supported person:	6. Region (circle one): 1 2 3 4 5
7. Is someone other than the person responding to the survey (if the person is not able to answer one or more of the questions independently)? If NO skip to Section B If YES , answer 7a – 7b	<input type="checkbox"/> Yes <input type="checkbox"/> No
7a. If yes, what is the First and Last name of the person assisting with responses?	
7b. What is his/her relationship to the person? <input type="checkbox"/> Child <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> (Other)Family <input type="checkbox"/> Friend <input type="checkbox"/> DSP <input type="checkbox"/> Guardian	

Section B: HCBS Setting Experience Overall All participants are required to complete this section

Question:	Response:	HCBS Setting Requirement:
1. Do you have your own bank account?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Allows person to control personal resources.</i>
2. Do you have access to your money?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Can you buy the things you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Did someone tell you about the services and supports available to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Facilitates personal choice regarding services and supports and who provides them.</i>
5. Did you choose the services and supports you receive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Were you given options to choose from when selecting the agency that provides your services and supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Did you choose the specific person/people who provide your services and supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Do you know how to request a change in your services and supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Do you know how to request a change in who provides your services and supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Does this person participate in Employment or Day Services? If yes, complete Section C; If no, SKIP Section C

Section C: Employment and Day Services

10. Select the funding for Employment/Day Service(s) the person is receiving	<input type="checkbox"/> ID Waiver <input type="checkbox"/> LAH Waiver <input type="checkbox"/> ADRS
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11. Name of Service Provider	Address	
Does the person have more than one Employment/Day services provider? If yes, enter the 2nd provider name; If no, skip to question 1		
12. Name of 2 nd Service Provider	Address	
Question:	Response:	HCBS Setting Requirement:
1. Do you have a job?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Provides opportunities to seek employment and work in a competitive environment.</i>
2. Could you have a job if you want one?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Do you have the help you need to look for a job if you want one?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Can you be alone if you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Ensures person's rights of privacy, dignity, respect and freedom from coercion and restraint.</i>
5. Can you have a private conversation without others listening?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Is your personal information kept secure so others can't see it?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Do the people who support you treat you the way you want to be treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Do the people who support you listen to your questions or concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. If you want to, can you go out in the community?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Integrated, and supports, access to the broader community.</i>
Does the person participate in Residential Services? If YES, complete Section D; If NO, SKIP Section D		(circle YES or NO)
Section D: Residential Services		
Select the waiver funding source for the residential services the person is receiving	ID Waiver	LAH Waiver
Name of Service Provider	Address	
How long have you lived in your current residence?	Weeks/Months/Years	
Question:	Response:	HCBS Setting Requirement:
1. Did you choose where you live and receive services/supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>The setting was selected by the person from among setting options, including non-disability specific settings.</i>
2. Did you visit other places before choosing this one?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Do you know how to relocate and request new housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Do you own your home or have a lease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Specific unit or dwelling is owned, rented or occupied under a legally enforceable agreement.</i>
5. Do you know your rights as a tenant and protections from eviction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Can you close and lock your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Unit has lockable entrance door.</i>
Question:	Response:	HCBS Setting Requirement:
7. Do you have a key to your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Unit has lockable entrance door.</i>
8. Does anyone else have a key to your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Do others knock before entering your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Can you close and lock your bedroom door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Each person has privacy in their sleeping or living unit.</i>
11. Can you close and lock your bathroom door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Did you get to decide who has a key to your bedroom or bathroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Do others knock before entering your bedroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Were you given the option of a private room if you could afford it?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Option for a private unit.</i>

15. Can you choose who you share your room with?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Choice of roommates.</i>
16. Did you choose your roommate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Do you like living with your roommate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Do you know how to request a roommate change?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Did you decorate your room?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Freedom to furnish and decorate.</i>
20. Can you move the furniture where you want?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Can you hang or put up pictures if you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Can you change the decorations in your room?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23. Do you participate in activities like shopping, going to church or having lunch with family and friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Integrated in and supports full access to the greater community.</i>
24. Do you know how to find out about upcoming events or activities that you might have an interest in?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Do you have the help you need to participate in the activities you want to do?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26. Are you able to get to the activities you would like to participate in?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Do you make your own schedule?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Freedom and support to control schedules and activities.</i>
28. Can you decide when you get up, take a bath, eat, exercise or participate in other activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
29. Can you watch television, listen to the radio and do things that you like when you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
30. Can you eat when you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Access to food at any time.</i>
31. Can you eat where you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
32. Can you eat what you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
33. Can you request a different meal if you want one?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
34. Are snacks accessible and available anytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question:	Response:	HCBS Setting Requirement:
35. Can you have visitors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Allow visitors at any time.</i>
36. Can you have visitors at any time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
37. Can you have private visits with family & friends if you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
38. Do you have the supports you need to move around your room/house as you choose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Physically accessible.</i>
39. Can you enter and exit your room/house as you choose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
40. Do you have full access to the common areas such as the kitchen, dining area, laundry, and shared living areas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
41. Do you have a resident handbook or know how to get one? (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Policies outlining personal rights are available and accessible to the person.</i>
42. Do you understand the handbook or know who to ask if you have questions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
43. Do you have access to a phone, computer or other technology?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

44. Do you have access to transportation to go the places you want to go?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Optimizes personal initiative, autonomy, and independence in making life choices.</i>
45. Can you make decisions about your schedule, where you go, who you see, and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the person participate in Personal Care Services? If yes, complete Section E; If no, SKIP Section E		(circle YES or NO)
Section E: Personal Care Services		
Select the waiver funding source for Personal Care services the person is receiving	ID Waiver	LAH Waiver
Name of Service Provider	Address	
Question:	Response:	HCBS Setting Requirement:
1. Do you live with family in a family member's home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Choice in living arrangement.</i>
2. Do you live in your own home or apartment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Can you live in your own home or apartment if you want?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Do you have the help you need to participate in the activities you want to do? <i>For example, are you able to get to the activities you want to participate in and the support you need to participate in those activities?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Integrated and supports access to the greater community.</i>
5. If you want to, can you go out in the community during the day? <i>For example, do you participate in activities like shopping, going to church or having lunch out with family and friends?</i> If Yes, how often?	<input type="checkbox"/> Every time I want to <input type="checkbox"/> Most of the time I want to <input type="checkbox"/> Not as much as I would like	<i>Integrated and supports access to the greater community.</i>
Question:	Response:	HCBS Setting Requirement:
6. Other than family or paid caregivers, do you spend time with people who do not have disabilities? If yes, how often?	<input type="checkbox"/> Every time I want to <input type="checkbox"/> Most of the time I want to <input type="checkbox"/> Not as much as I would like	<i>Integrated and supports access to the greater community.</i>
7. Do you know how to find out about upcoming events or activities in your community?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Provides opportunities to seek employment or volunteer opportunities.</i>
8. If you want to, can you have a job or volunteer? <i>For example, do you have the support you need to look for a job or volunteer somewhere if you want?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Can you change how and where you receive personal care supports if you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>The service facilitates personal choice regarding services and supports and who provides them.</i>
10. Can you be alone if you want/need to be while receiving personal care services? <i>For example, can you have a private conversation without others listening?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Ensures person's rights of privacy, dignity, respect and freedom from coercion and restraint.</i>
11. Do the staff who support you treat you the way you want to be treated? <i>For example, do staff listen and respond to your questions or concerns?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Do you have adequate privacy in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

13. Can you close and lock your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Unit has lockable entrance door.</i>
14. Do you have a key to your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Are you comfortable with the other people who have keys to your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Do others knock before entering your bedroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Each person has privacy in their sleeping or living unit.</i>
17. Can you close and lock your bedroom door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Can you close and lock your bathroom door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Are you comfortable with the other people who have a key to your bedroom or bathroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question:	Response:	HCBS Setting Requirement:
20. Can you eat when you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Access to food at any time.</i>
21. Can you eat where you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Can you eat what you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23. Are snacks accessible and available anytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
24. Do you have the supports you need to move around your room/house as you choose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Physical accessibility.</i>
25. Can you enter and exit your room/house as you choose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26. Do you have full access to the common areas such as the kitchen, dining area, laundry, and shared living areas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Do you have access to a phone, computer, or other technology?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Optimizes personal initiative, autonomy, and independence in making life choices.</i>
28. Do you have access to transportation to go to places you want to go?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
29. Can you make decisions about your schedule, where you go, who you see, and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Revisions to Person Centered Plan Required: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, describe areas to be addressed:</i>		
Remediation Plan Required: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, describe areas to be addressed:</i>		
Signature of Support Coordinator:	Date forwarded to Provider/Monitor:	

4.6. RFA Recoupment Policy

Responsible Office: System Management

Reference: RFA Procedures O.G 6.3

Statement: Support Coordinator agency found out of compliance with the RFA procedures may be subject to recoupment of funds for repeated violations to the RFA process.

Purpose/Intent: To protect the program integrity and demonstrate financial accountability.

Scope: Regional Offices, Support Coordination/Case Management Agencies, Providers, Central Office

Definitions: RFA: Request for Action

Procedures: Steps to protect integrity of Support Coordination service delivery relating to unit utilization.

1. Provide training to the following Regional Staff about the recoupment process to include the following: Technical Assistance professionals, Community Service Directors, Waiver Coordinators, Support Coordinator Liaisons and Fiscal Officer.
2. Provide training to Support Coordinators on the recoupment process.
3. The Support Coordination Liaison/Monitor will conduct an initial review 60 day after training is provided to community Support Coordinators.
4. Based on results of the initial review, they will provide additional training where needed along with Technical Assistance.
5. Provide a follow-up review 60 day from the date of the second training and Technical Assistance.
6. If concerns are reflected in the second review (after second training and/or additional Technical Assistance), the Regional Office Support Coordinator Monitor will make recommendations to the Central Office Technical Assistance Team (Director of Systems Management, Fiscal Officer and the Associate Commissioner or their designee) to recoup funds as appropriate.
7. The Central Office Fiscal Manager will recoup funds as determined necessary. The Department's internal auditor may be called upon to evaluate findings and make recommendations as needed.
8. Ongoing monitoring will be provided through the Support Coordination/Case Management Monitoring tool.

CHAPTER 5

PROVIDER REQUIREMENTS AND OTHER INFORMATION

5.1. New Provider Enrollment

Responsible Office: Office of Quality and Planning/Certification

Reference: ADMH Administrative Code 580-3-23-.09; ADMH Policy 540-003, 550-001; Certification of Community Programs; 580-3-25 Administrative Review for the Certification of Community Programs; 580-5-33 Administrative and Support Requirements for Community Providers of DD Services; OG 6.9

Statement: After completion of the New Provider orientation, the prospective provider will have all the necessary information required to complete and submit an application seeking approval to become a provider of services and supports.

Purpose/Intent: To provide a step by step process to Prospective Providers of becoming a certified provider of DD services and supports.

Scope: Office of Quality and Planning, Prospective Community Providers, Office of Certification Administration, Regional Community Service Offices and Fiscal Office.

Definitions:

Procedures:

Phase ONE - Overview

1. Prospective provider completes online training

Phase TWO – Orientation (capacity 50)

2. Prospective provider attends live event session
 - a. Morning session covers general information
 - b. Afternoon session covers DD specific information
 - Application package received after sign-in and contents reviewed
 - PowerPoints presented
 - HCBS Settings Rule requirements (PowerPoint)
 - Regional Office Locations
 - Services available to provide
 - Application Process
 - Provider requirements overview
 - Managed funds
 - Organization’s Name
 - Questions answered
3. Prospective provider MUST complete entire orientation to continue process
4. Prospective provider completes application and submits it to ADMH Office of Certification Administration (OCA)
5. Prospective provider must submit application package within 1 year of attending orientation
6. OCA submits background check to BSI
7. BSI forwards completed background check to OCA
8. OCA forwards application package w/background check to the Office of Certification

- a. If BSI reports prospective provider meets requirements, application moves to next step
 - b. If BSI reports prospective provider does not meet requirements, application package is denied, and a notification is sent to applicant
9. Application package is reviewed by the Office of Certification. **All supporting documentation from the following checklist must be submitted with the application.**

ALABAMA DEPARTMENT OF MENTAL HEALTH
 DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
 CERTIFICATION APPLICATION AND SUPPORTING DOCUMENTATION

SERVICES TO BE PROVIDED TO TARGETED POPULATION

Use the letters and numbers below to complete the chart below. For example, if you propose to have Residential Services for men and women, put C in the Gender Served column, 1, 2, or 3 in the Age Group column, and the total number of people in the Number to be Served column.

Gender Served

- A = Male
- B = Female
- C = Both

Age Group

- 1 = Children (4-12)
- 2 = Adolescents (13-20)
- 3 = Adults (21+)

Services to be Provided	Gender Served	Age Group Served	Number to be Served
Supported Employment Services			
Hourly Services-Personal Care or Respite			
Day Habilitation			
Other (specify)			

BACKGROUND INFORMATION

1. Have you, your corporation or any other businesses owned/operated by you, or the business entity that is the subject of this application ever been the subject of any investigation for fraud or false claims related to Medicaid or any other state or federal program, or have you, your corporation, or any other businesses owned/operated by you, or the business entity you now represent ever been found in either an administrative or judicial proceeding to be guilty of fraud or false claims in conjunction with Medicaid or any other state or federal program?

_____ Yes

_____ No

If yes, please provide a complete explanation (attach separate page if necessary) of the allegations, proceedings if any, and disposition if any.

2. Have you, your corporation or any other businesses owned/operated by you, or the business entity that is the subject of the application, or any business entity in which you have an ownership or control interest* ever had an application for certification denied by the Alabama Department of Mental Health (ADMH) or by any other state or federal licensing/certification authority , or having been certified or licensed by any such authority, have you, your corporation of any other business owned/operated by you, or the business entity that is the subject of this application, ever had a license/certification revoked or been decertified by the Alabama DMH/MR or by any other state or federal licensing/ certification authority.

_____ Yes _____ No

If yes, please provide a complete explanation (attach separate page if necessary) of the circumstances surrounding the denial, revocation or decertification and the final disposition of the same.

* An individual is considered to have an ownership or control interest in a provider entity if he has direct or indirect ownership of 5 percent or more, or is a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity as defined in under 42 CFR section 1001.1001(a) (1).

DOCUMENTS TO BE INCLUDED WITH APPLICATION

1. _____ Copy of transcript as proof of degree (Executive Director/Owner/Operator)
2. _____ 5 years' experience with service provision to ID population (Executive Director/Owner/Operator)
3. _____ Articles of Incorporation/Articles of Organization
4. _____ Board Bylaws/ LLC Operating Agreement
5. _____ Board/Executive Committee minutes for the past year
6. _____ Documentation indicating at least a 90-day cash reserve for operations
7. _____ Fiscal Policy (Organizational Fiscal Practices. Covers at least accounting guidelines, risk control, financial planning, financial reporting, revenue and expenditures, and asset management.)
8. _____ Operational Budget
9. _____ Organizational Chart
10. _____ Curriculum vitae (resume) of executive director
11. _____ Description of primary geographic area to be served
12. _____ Copy of the program policies and procedures
13. _____ Basic Assurances Plan
14. _____ Copy of individual rights policies and procedures
15. _____ Emergency Crisis Response Plan
16. _____ Written Description of each program for which certification is requested
17. _____ Vitae (resume) of Clinical Director, Program Coordinators, Directors, Supervisors, Qualified Intellectual Disabilities Professional (QIDP)
18. _____ Copy of staff training required prior to staff working with individual receiving services
19. _____ Copy of staffing pattern for services to be provided
20. _____ Prospective Provider Certificate of Attendance

Untruthful/fraudulent information may be cause for denial of an application. No future applications will be considered.

If you are a currently certified entity submitting an application for a new sub-contractor, you must submit all items listed above.

If you are currently certified as a sub-contractor and wish to be an independently certified entity you must submit all items listed above.

If you are a currently certified entity adding a program or service, please complete 12 through 15 only.

10. If application package does not meet criteria, package is either returned to applicant for additional information or denied and returned to applicant. Reasons for not approving applications:
 - a. Unfavorable background check for Executive Director (ED) (can reapply with new ED)
 - b. Falsification of information (cannot apply again)
 - c. Lack of educational background for Executive Director (can reapply with new ED)
 - d. Lack of required experience (5 yrs.) for Executive Director (can reapply with new ED)
 - e. Application reviewed 3 times
 - f. Pattern of substantiated incidents of abuse, neglect, mistreatment, and exploitation
 - g. Setting does not meet HCBS Settings Rule
 - h. Presence on the Exclusion List
 - i. Agency has demonstrated an inability to take on added responsibility of additional setting or service (can reapply after next favorable full review)
 - Provisional Certification
 - Extended TOA (s)
 - j. Previously Decertified
 - k. Inappropriate name for organization (can reapply with favorable name)
11. If application package meets criteria, application is approved and sent to OCA for issuance of a Temporary Operating Authority to provide services
12. OCA notifies applicant of approval and TOA issuance and requests \$1,500 application fee. Once application fee is received by OCA, OCA notifies Office of Certification and Regional Office of new provider status

Phase THREE – Selection of “Setting”

13. Provider submits application for ‘proposed’ setting location to OCA
14. OCA forwards application for proposed setting to Regional Office by email
15. Regional Office returns application for proposed setting by email to OCA with recommendation of approval or denial
16. OCA forwards application for proposed setting, with Regional Office recommendation, to Office of Certification
17. Office of Quality and Planning reviews and signs application for proposed setting and returns to OCA
 - l. If application is denied, provider is notified and chooses another setting
 - m. If application is approved, 6- month Temporary Operating Authority (TOA) is granted following Life Safety inspection
18. Life Safety inspects property and issues report approving or denying with recommended corrections. Once final approval is provided, OCA issues a TOA
19. OCA notifies Alabama Medicaid Agency (AMA), Office of Certification, and Associate Commissioner of the TOA
20. Office of Certification assigns a setting number and notifies Office of Systems Management (OSM), and Regional Office

21. Regional Office notifies appropriate 310 Authority for Targeted Support Coordination (TSC) so the provider can be placed, as an option, on the Free Choice of Provider List
 22. Regional Office Fiscal Staff initiates contract process and establishes a \$1.00 place holder contract
- If no services are provided in the setting at the end of the 6-month certification date, the TOA must be renewed

Phase FOUR – New Provider Orientation

23. Overview of ID Services
 - a. Scope of Waivers
 - b. HCBS
 - c. Operational Guidelines Manual
 - d. Funding and Maintaining Eligibility
 - e. Waiting List/Placement
 - f. Supported Employment
 - g. Housing
 - h. Community Integration
24. Fiscal Management
 - i. Contract Process
 - j. Billing and Claims
 - k. IRBI
25. Community Services
 - l. Provider Self-Assessments
 - m. Validation/Monitoring/POA Process
 - n. Special Team Meeting
 - o. IPMS
 - p. Nursing
 - q. Regional Technical Assistance
26. Comprehensive Support Services
 - r. Behavioral Support Planning
 - s. Crisis Management
27. Certification
 - a. Administrative Code
 - b. Certification Overview
 - c. HIPPA
 - d. Person-Centered Planning
28. Quality Enhancement
 - a. Person-Centered Thinking
 - b. Fatal Five
 - c. Basic Assurances (Factor 10 Training)
 - d. 4-Day POM Training
29. Support Coordination
 - a. Case Management/Support Coordinator Training
 - b. Role of Support Coordinator
 - c. Choice Process
 - d. Overview of Functional Assessments
 - e. Person Centered Planning Facilitation
 - f. Plan of Care
30. Advocacy & Rights Protection

- a. Rights Training/Assessment
- 31. Nurse Delegation Program
 - a. Alabama Board of Nursing Data Collection
 - b. MAS Nursing
 - c. Level 2 & 3 Medication Error Forms
 - d. NDP Certification Score Sheet

Phase FIVE – Initiation of service to Medicaid Beneficiary

1. Medicaid beneficiary notifies TCM of choice of new provider
2. Packet is completed to include Provider Agreement and Provider Disclosure and sent to OSM
3. OSM forwards packet to AMA
4. AMA performs fraud review and if none, issues a Provider Number
5. SM enrolls provider in DDD IMS
6. Provider **bills** to date of Medicaid beneficiary’s beginning service date

Phase SIX – HCBS Settings Rule Compliance (MUST MEET 100% COMPLIANCE)

1. Provider should have met all HCBS Settings Rule criteria except for the Individual Experience Assessment prior to Medicaid beneficiary’s service date
2. After transition occurs, the Individual Support Coordinator’s first three monthly contacts occurs face-to-face. One visit will occur within 55-65 days to complete the Individual Experience Assessment (IEA).
3. The IEA must be completed by Support Coordination Services (SCS) between 55-65 days and make needed adjustments to the Medicaid beneficiary’s Person-Centered Plan (PCP) as appropriate. SCS should provide a copy of the IEA to the provider’s Regional Office (RO) Monitor for HCBS Settings Compliance review. The RO monitor completes validation within 60 days of the provider completing the (HCBS) self-assessment. The provider then has 30 days to make corrections that meet expectations for 100% compliance
4. At 90 days, if provider does not meet 100% compliance with the HCBS Settings Rule, the TOA is withdrawn, and Emergency facilitation of CHOICE meetings begin
5. At 90 days, if provider meets 100% compliance with the HCBS Settings Rule, the TOA remains in good standing
6. Certification completes a review of the TOA setting before the end date of the 6-month certification
 - b. For new provider, full review is conducted once an individual has been admitted before the end of the TOA
7. For established provider, a review of the TOA setting is conducted once an individual has been admitted before the end of the TOA certification date. If all qualifications are met, the setting is aligned with the agency’s certification date.
8. HCBS Settings Rule compliance monitoring continues with 6-month monitoring visits

5.2. Temporary Operating Authority (TOA) Process

Responsible Office: Quality and Planning/Certification

Reference: ADMH Administrative Code 580-3-23-.08 (1) & (7); ADMH Policy 550-001

Statement: Once a provider's application is approved for a new setting or new service, the program is issued a letter of Temporary Operating Authority by the DMH/DD Commissioner allowing it to operate for a period up to 6 months.

Purpose/Intent: To provide providers with the TOA process.

Scope: Office of Quality and Planning, Community Providers, Office of Certification Administration, Regional Community Service Offices

Procedures: The provider submits an application for a new setting or service to the Office of Certification Administration (OCA). The OCA logs application pack and criminal background check notification from BSI. The OCA forwards the application to the Regional Community Services (RCS) Office for review and recommendation.

RCS returns the application with the Application and Setting Review form and any supporting documentation **for all new settings**, to the OCA. The OCA forwards application and RCS recommendation with supporting documentation to the Office of Quality and Planning (OQP) for review and approval.

The OQP reviews application and supporting documentation.

1. Approved for Certification: If for a new setting, the application is approved for a 6-month TOA following the Life Safety inspection and is returned to the OCA.
2. Approved for Certification: If for a new service, the application is approved for a 6-month TOA and is returned to the OCA. Life safety is not required.
3. Not Approved for Certification: If for a new setting or new service, the application is not approved and a letter detailing the denial is returned to the OCA.

For a new setting, the OCA forwards requirement to Life Safety inspection for scheduling.

Life Safety completes a review.

1. Setting passes: Life Safety review, documentation/application returned to OCA.
2. Setting does not pass: Provider given opportunity to correct deficiencies, if possible, or can opt to acquire another property. If provider chooses to acquire new property, process starts over. Documentation/application returned to OCA.

The OCA prepares a letter of TOA for new setting and new service for the Commissioner's signature. The OCA sends TOA to provider, OQP, and Medicaid.

The OQP notifies RCS and the Central Office Application Support Specialist of the TOA and provides a new setting/new service number.

- Prior to expiration of the TOA, if there are no people receiving services in the setting, the provider must resubmit another application to the OCA.

ADMH-DDD Regional Community Services		Application and Setting Review	
Provider Name:			
Date new application received:		Provider Status: <input type="checkbox"/> New <input type="checkbox"/> Existing	
Part A To be completed by Regional Community Services (RCS) Office -			
1. Is the setting adjacent to or under the same roof as a building that houses a publicly or privately-operated setting which provides inpatient institutional care: skilled nursing setting (SNF), immediate care setting for individuals with intellectual disabilities (ICF/IID), institute for mental disease (IMD), or hospital?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Is the setting located on the grounds of, or immediately adjacent to, a building that is a public institution which provides inpatient institutional care (Skilled Nursing Setting (SNF), Intermediate Care Setting for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Disease (IMD), or hospital?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Does the setting otherwise have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS and therefore, presumed institutional? a. If the answer is YES, what evidence is provided to overcome the presumption of an institutional setting?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Does the setting have more than 6 beds?		___ Yes ___ No	
5. Would this proposed setting be located on the same street, court, etc., where these types of settings constitute more than 25% of all settings?		___ Yes ___ No	
6. Is the setting adjacent (next to or shares a property line) to another setting?		___ Yes ___ No	
IF ANSWER TO 4 – 6 IS YES, DO NOT PROCEED, SIGN FORM AND FORWARD TO OCA			
7. Is the setting physically accessible, and free from obstructions such as steps, lips in a doorway, narrow hallways, etc., or otherwise have any other safety concerns such as lighting, unsanitary conditions, exposed electrical wiring, area known for violent crimes, drug use, etc.?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Is the site recommended for Life Safety inspection?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Comments/Observations:			
Name of person completing Assessment:			Date:
Forward to the Office of Certification Administration (OCA)			
Part B To be completed by the Office of DD Certification – NOTE: Expanding providers complete 1-3; New providers complete 3			
1. Is the agency currently on a Provisional Certification status?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Has the agency been on a Provisional Certification within the last two regular site visits?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If answer to 1 or 2 is “YES”, do not proceed with application! Return to OCA!			
3. Is the setting approved for a 6-month Temporary Operating Authority (TOA) following Life Safety inspection?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Comments:			
Name of DDD Certification Staff:			Date:
Forward to the Office of Certification Administration (OCA)			
Part C To be completed by the Office of Certification Administration			
Sent to Life Safety:			Date:
Additional Comments:			
OCA Director Signature			Date:

5.3. New Provider Enrollment with Alabama Medicaid Agency

Responsible Office: System Management

Reference: Administrative Code 580-5-30-.12; Alabama Medicaid Provider Manual, OG# 4.1

Statement: New Providers will be enrolled with the Alabama Medicaid Agency's Fiscal Management Payment System (FMPS)

Purpose/Intent: To ensure new providers are enrolled as required to submit claims data and receive payment for service provision

Scope: For all new providers

Definitions: DDD IMS (Division of Development Disabilities Information Management System)

Procedures: Once a new provider has been certified or receives a temporary operating authority (TOA), notification is sent to the appropriate regional office.

- 1 The Regional office provides enrollment forms that include:
 - a. The Provider Agreement
 - b. Disclosure Form
- 2 Providers complete the required forms and return the originals to the Regional Office for review before forwarding to the DD Central Office Application Support Specialist.
- 3 The Application Support Specialist reviews the forms further and collects any required missing information.
- 4 Contract site is monitored for indications of a fully executed contract
- 5 Upon contract completion, the Enrollment Packet is finalized and sent to AMA Fiscal Management Payment Interchange System for enrollment. Enrollment Packets include the following forms:
 - a. ADMH Provider Agreement(s)
 - b. Disclosure Form(s)
 - c. FMPS Enrollment form for appropriate waiver(s)
- 6 Interchange is monitored for completion of enrollment and assignment of the Medicaid provider number.
- 7 When a Medicaid Provider number is assigned, the provider is added to the DDD IMS sites (TEST and LIVE).
- 8 The Regional Office Fiscal Officer notified the process of enrollment is completed.

5.4. Validation of Provider HCBS Self-Assessment

Responsible Office: Regional Community Services

Reference: ADMH DDD Residential Setting Self-Assessment; ADMH DDD Non-Residential Setting Self-Assessment; ADMH DDD Benchmark Guide for Adult Residential Programs; ADMH DDD Benchmark Guide for Adult Non-Residential Programs

Statement: The Regional Community Services staff will validate provider responses to the Residential and Non-Residential HCBS Self-Assessments.

Purpose/Intent: The validation process will ensure setting adherence to the HCBS Settings Rule and will involve communication between the Regional Monitor, the provider, and the Community Services Director, with findings shared with the Director of Planning and Quality Enhancement.

Scope: Regional Community Services; Director of Community Programs, Director of Planning and Quality Enhancement; Providers

Definitions: HCBS (Home and Community Based Services); DDD IMS (Division of Developmental Disabilities Information Management System); CSD (Community Services Director); QE (Quality Enhancement)

Procedures:

1. Regional Monitors will review the HCBS Self-Assessment Tool for the assigned setting in DDD IMS.
 - a. If the HCBS Self-Assessment is incomplete or is not submitted by a Provider:
 - i. On May 15, 2019, the Provider will be notified in writing of the need to immediately complete and submit the Self-Assessment.
 - ii. If no HCBS Self-Assessment is submitted by May 31, 2019, a second letter will be generated for the Provider, outlining the contractual consequences of failure to comply with the Self-Assessment mandate.
 - iii. If no HCBS Self-Assessment is submitted by August 31, 2019, the assigned Regional Monitor will, by September 30, 2019, conduct a routine monitoring visit, for the purpose of ensuring basic health, safety and security, as per the previously established monitoring process.
2. Regional Monitors will schedule a visit to the assigned setting with a 7-day advance notice to the Provider.
3. Regional Monitors will make all necessary arrangements with the Provider to:
 - a. Review the required documentation that supports the Self-Assessment.
 - b. Meet with and interview (at the site) those receiving services there, as well as an employee of the Provider agency knowledgeable of the information required to complete the Validation Tool.
 - i. For Non-Residential settings, a minimum of 10% of Person-Centered Plans (PCP's) and associated documentation must be reviewed.
 - ii. For Residential settings, 100% of Person-Centered Plans (PCP's) and associated documentation must be reviewed.
4. Regional Monitors will complete the visit, enter the validation review into DDD IMS, including findings requiring Provider action into the Setting Transition-to-Compliance Plan, and provide a copy of the report to the Provider within 10 days.
5. The Provider will have 15 business days to complete the Setting Transition-to-Compliance Plan, providing methods and timeframes for resolving all validation findings for the setting demonstrating non-compliance or partial compliance with the HCBS Settings Rule.
 - a. During a validation visit by the Regional Monitor, any incidental findings that directly impact rights, restrictions, health, safety and/or security of persons served must be resolved by the Provider in advance of submission of the Setting Transition-to-Compliance Plan and submitted separately to

- the Monitor by email, to include date and method of resolution, along with accompanying substantiating documentation.
- b. Upon receipt, the Regional Monitor reviews the Setting Transition-to-Compliance Plan to ensure that it adequately addresses all validation findings and then submits it to the CSD/designee.
 - i. If the Setting Transition-to-Compliance Plan does not address all validation findings or does so inadequately, the Regional Monitor provides that feedback to the Provider via email within 15 business days, copying the Community Services Director (CSD)/designee.
 - ii. The Provider then has 10 business days from the date this feedback is delivered to correct the plan and re-submit.
 - iii. The Regional Monitor will contact the Provider about the revised plan within 15 business days.
 - c. If the Provider comprehensively resolves some validation findings prior to submission of the Transition-to-Compliance Plan, these findings are still to be included in the Setting Transition-to-Compliance Plan with date and method of resolution, along with accompanying substantiating documentation.
 - d. If the Setting Transition-to-Compliance Plan is not submitted, the Regional Monitor will inform the Community Services Director/designee on the 16th day, and the CSD/designee will contact the Provider immediately to request submission.
 - e. Once the Setting Transition-to-Compliance Plan is received and deemed complete by the Regional Monitor, they will notify the CSD/designee that it is available for review.
6. The CSD/designee will review/approve the Provider Transition-to-Compliance Plan within 7 business days of receipt of the completed plan.
 - a. If the Setting Transition-to-Compliance Plan is not submitted within specified timeframes or is not accepted upon resubmission, the Regional Office will require the Provider to participate in assigned Technical Assistance pertinent to the identified area(s) of concern.
 - b. The Provider will be given 30 days to complete the Technical Assistance and re-submit the Setting Transition-to-Compliance Plan.
 7. The Regional Office will meet with all Regional Monitors (to include QE, Certification, or any regional office staff) at least monthly, to discuss the Setting Transition-to-Compliance Plans, so as to identify Providers demonstrating difficulty transitioning to HCBS compliance, note cross-Provider trends in compliance, identify areas of needed technical assistance, etc.
 8. The Regional Office will collect data on each setting's compliance with each part of the rule as evidenced by the Setting Transition-to-Compliance Plans and progress made on resolving each of the findings identified, and provide monthly reports of such to the Director of Planning and Quality Enhancement for those settings completed during that particular month.
 9. The CSD/designee will coordinate Technical Assistance with the Provider, to be completed by corresponding DMH staff, as assigned.
 10. After completion of the validation review, the Regional Monitor will follow the same process within six months to review the assigned setting again and review specific progress achieved or not achieved with regard to the approved Setting Transition-to-Compliance Plan.
 11. Thereafter, and until September 30, 2021, the Regional Monitor will twice annually utilize an HCBS Validation Check List during routine monitoring to ensure that the Provider remains in compliance with the HCBS Settings Rule.

5.5. Monitoring of Waiver Services

Responsible Office: Regional Community Services

Reference: ADMH Administrative Code 580-3-23-.13 through 580-3-23-.15

Statement: Regional Community Services (RCS) staff in each Fiscal Region observe and assess provision of Waiver services (Residential, Day and Supports) twice annually.

Purpose/Intent: Waiver services (Residential, Day and Supports) are monitored twice annually to ensure they are administered according to CMS and ADMH standards.

Scope: Regional Community Services; Director of Community Program

Definitions: CMS (Centers for Medicare and Medicaid Standards); RCS (Regional Community Services); CSD (Community Services Director); POA (Plan of Action); DDD (Division of Developmental Disabilities)

Procedures:

1. The Regional Monitor monitors every certified DMH/DD setting twice annually, once each during periods April 1 – September 30 and October 1 – March 31.
2. The Regional Monitor arrives to the setting unannounced, if possible. In the event two unannounced visits are attempted at disparate times, but no one is available at the setting, the Regional Monitor may contact the Provider directly to arrange a time when Waiver-served persons and Provider staff members will be present.
3. The Regional Monitor uses the corresponding Monitoring Tool (e.g., Residential, Day, or Supports) to complete the monitoring assignment, comprehensively addressing each item included and verifying with direct observation of substantiating documentation, interviews, and/or visual inspection, as appropriate.
4. In the event the monitoring visit yields findings that indicate immediate risks to health, safety or security, the Regional Monitor will immediately notify the Community Services Director (CSD) for determination of a safe and appropriate time frame for addressing the emergent finding(s) (e.g., 24 hours, immediately, etc.). It may be that the persons served at the setting should be temporarily relocated while the emergent findings are rectified. The Regional Monitor will then notify the Provider director/supervisor of the time frame for addressing the emergent findings and whether the persons served at the setting must be relocated until they are addressed.
5. The Regional Monitor completes the monitoring report and transmits to the Provider via email within ten (10) business days, delineating those findings requiring follow-up. The CSD/designee is to be copied on this email.
6. If the Provider receives a monitoring report that requires follow-up response(s), the Provider must address those findings and respond directly to the Regional Monitor within ten (10) business days with evidence of resolution for each.
 - a. Note that any emergent findings that were resolved during or before that 10-day period must be reflected in the Provider's response as resolved.
 - b. If there are findings that require more than 10 business days to resolve, the Provider is required to submit to RCS within the allotted 10 business days a Plan of Action (POA) for those findings, to include method and specific time frame of resolution.
7. If there are no findings requiring follow-up, or when all findings are fully and satisfactorily addressed, the Regional Monitor provides the closed monitoring report and, as applicable, substantiating documentation/evidence to the CSD/designee for review and notation of completion.
8. If the Provider does not satisfactorily address all findings within the allotted 10 business days, or if the POA submitted for any outstanding items is inadequate, inappropriate, or not satisfactorily resolved within the Provider's specified time frame(s), the Regional Monitor transmits a single prompt to the Provider on the eleventh business day after they were notified of the findings, with detailed explanation(s) and requesting final resolution. The CSD/designee is to be copied on this email.

- a. If the Provider does not respond to this prompt within five (5) business days, the Regional Monitor will notify the CSD and designee (if applicable) on the sixth business day.
 - b. The CSD will meet with the designee (if applicable) and the Regional Monitor to review the unresolved findings and to identify appropriate topics of Technical Assistance for the Provider.
 - c. The Regional Office will require the Provider to participate in the assigned Technical Assistance and then resolve the outstanding findings/provide substantiating evidence within 30 days.
 - d. If the Provider does not satisfactorily resolve all findings following provision of Technical Assistance, the provider's initial Monitoring Report and POA (if applicable) will be reviewed by the CSD for recommendation of a "For Cause Review" by DMH certification.
9. If a "For Cause Review" is warranted by DDD Certification, the provider will be placed on Provisional status. At this time, the provider will be required to follow the procedures specified in ADMH Administrative Code 580-3-23-.13 through 580-3-23-.15.
 10. For accountability purposes, the CSD/designee maintains a database of expected and actual Provider response/POA receipt dates.

5.6. Monitoring of Special Staffing

Responsible Office: Regional Community Services

Reference:

Statement: Special staffing is a restriction that will be monitored for proper implementation.

Purpose/Intent: Regional Community Services staff will maintain current records of special staffing for each Fiscal Region and ensure that staffing at Residential and Day sites is implemented as required for each individual restricted with special staffing.

Scope: Regional Community Services; Fiscal Manager

Definitions: RFA (Request for Action); Community Services Specialist (CSS); GER (General Event Report); Community Services Director (CSD); Regional Community Services (RCS); Comprehensive Support Services Team (CSST); Behavior Support Plan (BSP); Individualized Residential Budgeting Instrument (IRBI)

Procedures:

1. The Behavioral and Psychological Evaluator maintains a comprehensive list of each Waiver-served person restricted with Special staffing, whether for behavioral or medical reasons. This list includes the name of the Residential or Day provider responsible for the special staffing, as well as the physical address of the setting, the required staffing ratio (e.g., 1:1, 2:1, etc.), and the dates of approval and expiration of the special staffing restriction.
2. The Behavioral and Psychological Evaluator updates the special staffing list weekly, as special staffing for various persons is approved, terminated, or changed via the RFA process, and distributes the list via email to all RCS staff members for their reference.
3. RCS staff members assigned to monitor Residential and Day settings use the special staffing list to verify that the staffing provided on-site is consistent with what is required according to the updated special staffing list.
4. In the event staffing is not provided as documented according to the special staffing list, the Regional Monitor:
 - a. Contacts the director of the provider agency (or an assigned supervisor) to ensure that the required staffing is provided as soon as possible.
 - b. Directs the provider to complete a GER for this occasion of Neglect and submits via the Therap system.
 - c. Notifies the Community Services Director (CSD) and the corresponding Incident Manager.
 - d. The Incident Manager:
 - i. Makes notification of the Neglect allegation to the person served and their guardian/family, as well as to the assigned support coordinator and Advocacy.
 - ii. Requests a plan of correction from the provider, to be delivered within ten (10) business days.
 - e. The CSD:
 - i. Implements enhanced monitoring at the site, to a minimum of one visit per week by multiple RCS staff members for at least six (6) weeks. This enhanced monitoring is to include direct follow-up on the provider's plan of correction, required in 4.d.ii., above.
5. A second occasion of Neglect for inadequate staffing during the 6-week enhanced monitoring period will result in:
 - a. A recommendation of Provisional status for the provider to the Commissioner of Mental Health.
 - b. Immediate implementation of the choice process (with emergency temporary alternative placement, if necessary) to identify a new provider for the person. RCS staff must be present at the choice meeting.
6. If the special staffing restriction is not managed according to established and required standards (e.g., inadequate training of alternative behaviors; inadequate/inappropriate fading plan, etc.), the Behavioral and

Psychological Evaluator will immediately notify the provider of those specific aspects that remain out of compliance and provide notice of a 30-day time frame to finalize and implement corrections.

- a. In the event that the necessary corrections remain incomplete and/or unimplemented after 30 days, the Behavioral and Psychological Evaluator will:
 - i. Complete and submit a temporary IRBI for the person to Fiscal Management that reduces the daily Residential reimbursement rate to a typical, base (e.g., non-1:1, non-2:1) staffing rate;
 - ii. Refer the provider to the CSST for technical assistance; and,
 - iii. Require a plan of correction from the provider (within ten (10) business days) to address their timely and compliant handling of restrictions.
- b. If the provider's handling of the Special staffing restriction(s) remains out of compliance after 30 days of implementing their plan of correction and receiving technical assistance, or if they refuse technical assistance or provide no plan of correction, as required in 6.a., above:
 - i. The incident Manager will complete a GER for Neglect and make notifications to the person served and their guardian/family, as well as to the assigned support coordinator and Advocacy.;
 - ii. CSST will assume direct management of the BSP and associated Special staffing restriction;
 - iii. The Placement Coordinator will direct the assigned support coordinator to immediately implement the choice process (with emergency temporary alternative placement, if necessary) to identify a new provider for the person. RCS staff must be present at the choice meeting.
 - iv. The Behavioral and Psychological Evaluator will review any other Special staffing restrictions managed by the same provider for compliance and for the potential need for choice.

5.7. Regional Provider Meetings

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-30-.02

Statement: Regional Provider Meetings are conducted at least quarterly in each fiscal region and are organized by the applicable Regional Community Services office.

Purpose/Intent: Regional Provider Meetings are conducted to ensure ongoing communication with certified service providers and support coordinators about Waiver services, standards and accountability, and to offer opportunities for feedback and guidance, as well as progressive training on applicable standards, policies and processes.

Scope: Director of Community Programs; Regional Community Services; Support Coordinators; Service Providers

Definitions: N/A

Procedures:

1. Regional Provider Meetings are held at least quarterly in each of the five fiscal regions.
2. Prior to each meeting, an email is sent to all Providers and Support Coordination agencies requesting suggestions for topics, along with a save-the-date notification.
3. An email is sent to all Providers and Support Coordination agencies with the upcoming agenda, including any current mandatory topics, and final meeting arrangements.
4. The meeting is held on the identified date, with a sign-in sheet required.
5. Handouts are available to all providers, as applicable.
6. Copies of sign-in sheets and handouts are sent via email to Central Office Certification and Quality Enhancement.
7. Original records of the meeting are maintained at the Regional Office.

5.8. Provider Name Change Process

Responsible Office: Office of Quality & Planning

Reference: ADMH Administrative Code 580—5-33-.05 (3)

Statement: By following this process, providers will have all the necessary information required to when making a name change for their organization.

Purpose/Intent: To provide a process for agencies wanting to change their name.

Scope: Office of Quality and Planning, Office of Certification Administration, Fiscal Office, Office of Systems Management, Contracts Office.

Definitions: Division of Developmental Disabilities Information Management System (DDD IMS); Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DDD)

Procedures:

1. Provider contacts the Office of Quality and Planning in writing to discuss the appropriateness of the proposed name change prior to contacting IRS. This is to ensure the proposed name is in keeping DD Administrative Code regulations.
2. The Office of Quality and Planning contacts the Provider in writing of the preliminary approval of the name change. (Letter Attached)
3. Provider contacts and provides necessary information to the IRS requesting a name change.
4. Provider submits IRS paperwork and National Provider Identification (NPI) application to the Office of the Secretary of State.
5. Provider submits approved paperwork above to the Office of Certification Administration (OCA) with a one page application to request a name change.
6. The OCA forwards application and supporting paperwork to DD Certification and cc's the Contracts Office, Fiscal Office, and the Office of Systems Management. From this point forward through the process, all correspondence should be copied to all persons/offices involved until completion.
7. DD Certification reviews and approves and forwards to OCA.
8. OCA forwards to the Fiscal Office and Contracts Office.
9. The Fiscal Office Completes C1 Contract form and forwards to the Contract Office.
10. The Contracts Office completes new contract and forwards to Finance Office.
11. The Finance Office reviews and approves and forwards back to Contracts Office.
12. The Contracts Office notifies the provider of the approved name change via new contract, provider completes the contract and returns to the contracts office which obtains the commissioner's signature to execute the contract.
13. The Contracts Office forwards the information to Office of Systems Management.
14. The Office of Systems Management advises provider to submit claims for the first checkwrite of the next month (the largest) and then hold all claims until notified. During this time the request to change the name is forwarded to Medicaid.
15. Medicaid updates new name in Payment System.
16. Medicaid notifies the Office of Systems Management of updated name change.
17. The Office of Systems Management updates name change in DDD IMS and notifies all ADMH-DDD staff.
18. The office Systems Management notifies provider of name change in DD IMS and advises provider to contact STAARS and resume claims submissions.
19. Provider contacts STAARS.



KAY IVEY
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF MENTAL HEALTH
RSA UNION BUILDING
100 NORTH UNION STREET
POST OFFICE BOX 301410
MONTGOMERY, ALABAMA 36130-1410
WWW.MH.ALABAMA.GOV



LYNN T. BESHEAR
COMMISSIONER

Date

Recipient Name
Title
Agency Name
Agency Address
City, State Zip

Dear Recipient Name:

This letter is to signify approval of your organization's name change to _____. While we know you have other steps to finalize the change with the governing bodies in your county's or counties' areas, and other processes to complete, we have no opposition to such name change.

Sincerely,

Connie Batiste
Director of Quality and Planning

5.9 New Systems Software Releases

Responsible Office: System Management

Reference: DDD Information Management System Manual

Statement: All system users will be informed of updates to the system

Purpose/Intent: To ensure all users have the most updated information for consistency

Definitions: DDD IMS (Division of Developmental Disabilities Information Management System)

Procedures:

1. The functional analyst is notified and is provided the Release Notes by the vendor.
2. Once received, the functional analyst reviews each line item of new feature/software update provided in the Release Notes. According to specifications, each update is tested to assure changes were successful and did not affect other components of the system.
3. In the Release Notes, each line item's "Affected Area", "Topic", and "Summary" of events is reviewed and tested. End users are also asked to participate in the testing as it pertains to their duties.
4. Tests are conducted in the "Alabama Acceptance" site.
<https://fwtest.harmonyis.net/AlabamaAcceptance/Pages/Login.aspx?ReturnUrl=%2fAlabamaAcceptance%2f>
5. This test site should be updated by the vendor with the new release of the software version along with the current data
6. Once all testing is completed and approved by the functional analyst and management, the vendor is notified to push the updates from the test site, Alabama Acceptance Test Site, to the DDD IMS Live Site
7. [The DD Division Functional Analyst issue an e-mail for all system users as notification of the changes and/or updates in the system](#)

CHAPTER 6

QUALITY MANAGEMENT

6.1. Certification Review Process

Responsible Office: Quality and Planning/Certification

Reference: Administrative Code 580-5-33-.05 (3)

Statement: This process is to guide certification staff in assessing community providers' success in providing quality services and supports.

Purpose/Intent: To provide the process for certification of community providers of services to people with developmental/intellectual disabilities.

Scope: Office of Quality and Planning, Office of Certification Administration,

Definitions: Factor- The main topic in the administrative and support requirements for community providers of services. Indicator-Used to set expectations for each factor. Probe-Used to evaluate how well the organization meets each indicator.

Procedures: It is strongly recommended providers complete a self-assessment using the "Assessment Tool for Basic Assurances," prior to the review. This will enable providers to evaluate their own positions in regard to the standards and provide an opportunity to gather materials pertinent to the review.

1. One month prior to the review, the agency will be requested to submit a roster of all individuals receiving services through the organization, with demographic and other information pertinent to the review.
2. The Certification Staff will select a sample of people supported to use during the review.
 - If the population of the organization is 30 or less, the sample will be 2 people.
 - If the population of the organization is 31-60, the sample will be 3 people.
 - If the population is more than 60 people, the sample will be 5% up to a maximum of 15 people.
3. The Certification Staff reserves the right to increase the interview sample to better represent the population being supported by the organization.
4. Approximately one week prior to the review, the Certification Staff will notify the provider of people identified for the sample.
5. Provider staff will contact those individuals and arrange for interviews, reviews of records pertaining to those people, and follow-up conversations with staff who know them well.
6. The Certification/Quality Enhancement Staff will conduct a Personal Outcome Measures interview with each person in the sample.
7. The Certification Staff will conduct record reviews of each person in the sample. The staff will review assessments, medication administration records, person-centered planning documents, and other records to validate the organization's systems and practices.
8. Settings reviewed by Certification Staff will represent all types of settings in which services are provided by the organization and complement the persons to be interviewed. Certification Staff reserve the right to visit any setting in which services are provided receiving services.
9. Each organization will be assessed in the areas of:
10. Factor One: Rights Protection and Promotion
11. Factor Two: Dignity and Respect
12. Factor Three: Natural Support Networks
13. Factor Four: Protection from Abuse, Neglect, Mistreatment and Exploitation

14. Factor Five: Best Possible Health
15. Factor Six: Safe Environments
16. Factor Seven: Staff Resources and Supports
17. Factor Eight: Positive Services and Supports
18. Factor Nine: Continuity and Personal Security
19. Factor Ten: Basic Assurances[®] System
20. Factor Eleven: Other Requirements Supporting Protection, Health and Safety
21. Factor Twelve: Personal Care, Companion, Respite and Crisis Intervention Services, and Supported Employment Services at an Integrated Worksite (non-congregate services)
22. Factor Thirteen: Case Management Standards
23. (Factors 12 and 13 only if those services are provided)
24. The criteria for Factors Four- Protection from Abuse, Neglect, Mistreatment and Exploitation, Five- Best Possible Health, and Six- Safe Environments is set at 100%. The system and practice for all Indicators in each Factor must be present to meet the 100% mark. Additional requirements in these areas are captured in Factor Eleven, which is scored differently.
25. For Factors One, Two, Three, Seven, Eight, Nine, Ten, Eleven, Twelve, and Thirteen, each Factor is composed of several Indicators. Each of the Indicators in Factors One through Three and Seven through
26. Thirteen are assessed and a rating made on one of the following criteria:
27. Action Required (AR)-Incomplete planning and action.
28. Progress Noted (PN)-Planning and action has occurred with evidence of partial results.
29. Effective Results (ER) -Actions are demonstrating the desired results.
30. Probes, correlating with the requirements in Chapter 580-5-33, Administrative and Support Requirements for Community Providers of Developmental Disability Services, are included in this Assessment Tool as a means of discovering information about the Indicators and making rating decisions. They are not scored separately but are used to gather information to support the decision about whether the Indicator is being met satisfactorily.
31. The reviewer will decide about each indicator based on the information gathered through conversation, spending time with people, and review of documents. The reviewer will evaluate compliance with requirements within the indicator and then make a final determination about the indicator based on a preponderance of the information gathered. The reviewer will note Supporting Information for all Indicators rated "Action Required" (AR) and for those individual standards within Indicators rated "Progress Noted" (PN).
32. Each organization will be subject to the requirements in Factors and Indicators based on the types of services provided (see chart following this discussion). The total number of the Indicators applicable for that organization is multiplied by 80% to determine the required number of met Indicators for a One Year Certification and 90% for a Two-Year Certification. Rounding is applied to the nearest whole number, with .5 being rounded up. Individual Indicators determined by the reviewer to be not applicable for will be deleted from the total Indicators required for that organization and this will be factored into the scoring.
33. The organization's indicator rankings are added together to obtain the total number of indicators meeting the "Progress Noted" (PN) and/or "Effective Results" (ER) status.
34. If the organization does not meet the 100% criteria for Factors Four, Five and Six, AND/OR does not meet the minimum of 80% on other applicable Indicators, the organization will be determined not in substantial compliance with standards and will not be certified. The organization may be placed on Provisional Certification Status for up to sixty (60) days, and a Plan of Action to address Indicators rated "Action Required" and "Progress Noted" must be submitted to the Office of Certification Administration within thirty (30) days from receipt of the letter from that Office. Timeframes to come into full compliance with the indicators must be included in the Plan of Action. Failure to submit the Plan of Action within the time period specified may result in the immediate decertification of the organization's programs. Prior to the expiration of Provisional Certification status, the programs will undergo a follow-up site certification review

to determine future certification status. If the organization fails to come into full compliance during the follow-up site review, the Provisional Certification will be extended, and a new Plan of Action may be required. Continued failure to come into full compliance may result in a recommendation for Decertification to the Commissioner.

- 35. If the organization does not meet the 100% criteria for Factors Four, Five AND/OR Six, the organization will be required to participate in mandatory training from the Regional Community Services Office relating to the area(s) cited. Failure to participate may result in immediate decertification of the organization's programs.**
36. If the organization meets the 100% criteria for Factors Four, Five and Six, AND receives either PN or ER on a minimum of 80% of the other applicable Indicators, the organization is certified for one year and a Plan of Action to address Indicators rated "Action Required" and "Progress Noted" must be submitted to the Office of Certification Administration within thirty (30) days from receipt of the letter from that office.
37. If the organization meets the 100% criteria for Factors Four, Five and Six, AND receives either PN or ER on a minimum of 90% of the other applicable Indicators, the organization is certified for two years.
38. Certification Staff will review policies and procedures of the organization that provides information about systems and practices. Targeted interviews will focus on the specific reason the person was selected.
- Someone who has been involved in a recent allegation of mistreatment
 - Someone who has filed a grievance/complaint
 - Someone who has agreed to a restrictive intervention/rights limitation
 - Someone who has had a reportable incident in the last three months
 - Someone who has had an emergency room trip or hospitalization
 - Someone who has significant health care supports
 - Someone who has a modified diet (preferably texture)
 - Someone who is new to service
 - Someone who has consented to research
- Others will be reviewed to gain information about specific organizational practices. The Certification Staff may select people from this list as part of the representative sample or as additional people to have conversations about specific issues. However, this list is not exhaustive and/or mandatory. The selection of people for targeted interviews is tailored to the meet the characteristics and needs of each organization.
39. The Certification Staff will have additional conversations with direct support staff, professional staff and others to gather information about the organization's systems and practice and may also review additional documentation about the topic of interest.
40. In the course of spending time with people, targeted interviews or review with people selected to be in the sample, the Certification Staff may ask questions of other people supported.
41. The Certification Staff may have a conversation with at least one family member/advocate/ legally authorized representative. The selected person may be someone who is present during the review, related to someone in the sample, or someone who the Certification Staff has identified as someone who will be able to provide information helpful in reviewing the organization's systems and practices or it might be someone recommended by the organization.
42. The Certification Staff will review records for a sample of personnel, which will include staff providing services to people in the sample. The number varies depending on the amount of information needed to validate the organization's practices. Generally, the sample size will be 10% but no less than 6 people and no more than 30 people.
- Direct Support Staff
 - One person who has been employed 3 to 6 months.
 - One person who has been employed more than one year.
 - Professional Staff Examples (as applicable)
 - Nurse

- QDDP
 - Case Manager
43. The Certification Staff will have conversations with organization leaders about the systems and practices. Some questions will be focused on specific systems like the Human Rights Committee, Safety or Quality Assurances/Basic Assurances monitoring. Other conversations will be more general about policies or practices of the organization.
44. At the closing meeting, the Certification Staff will provide general feedback about their findings.

The following chart indicates how the Factors and Indicators are applied per organization based on the services provided:

Factors	Indicators	Services Provided by the Organization			Other Notes
		Case Mgt	Non-Congregate	Residential and/or Day	
Factor One	7	√ (6 indicators)	√	√	Indicator G not applicable to Case Management
Factor Two	5	√	√	√	
Factor Three	4	√	√	√	
Factor Four	6 (100% compliance)	√	√	√	
Factor Five	5 (100% compliance)	√ (4 indicators)	√	√	Indicator E not applicable for agencies not administering medications
Factor Six	4 (100% compliance)	√ (3 indicators)	√	√	Indicator D not applicable for Case Management
Factor Seven	4	√	√	√	
Factor Eight	9			√	
Factor Nine	4	√	√	√	
Factor Ten	3	√	√	√	Will be scored beginning October 2014
Factor Eleven	3	√	√	√	
Factor Twelve	3		√		
Factor Thirteen	7	√			
Number of Indicators Scored		33 (36 beginning Oct. 2014)	30 (33 beginning Oct. 2014)	36 (39 beginning Oct. 2014)	For organizations providing services in more than one category, indicators are added as applicable

6.2. Provider Training and Technical Assistance

Responsible Office: Quality and Planning

Reference: ADMH Administrative Code 580-30-.09 (2); Assessment Tool Basic Assurances

Statement: Quality Enhancement specialists provide training and technical assistance to community provider organizations in various system areas as required by the Division of Developmental Disabilities.

Purpose/Intent: This procedure sets out to identify areas in which service providers may need assistance with agency-specific processes, training and the development of policies and procedures to improve the quality of individual and organizational supports.

Scope: These procedures apply to all DDD employees, subcontractors, providers, vendors, consultants, volunteers, and governmental agencies that provide services and supports to people with intellectual and developmental disabilities.

Definitions: Basic Assurances: The internal monitoring system measures the most important elements and key functions of the organization. Data sources, methods for data collection and the type of data analysis to be performed are clearly identified for each function measured.

Qualified Developmental Disabilities Professionals (QDDP) is a DD professional with at least one year of experience working directly with persons with ID, holds a bachelor's degree in a human service field, and has completed a series of required training as referenced in the ADMH Administrative Code.

Procedures: Regional QE staff provide training and technical assistance in the following areas:

1. Basic Assurances System

- a. Alabama, in partnership with CQL, re-designed and implemented new Administrative and Support Requirements for Community Providers of Services for People with Developmental Disabilities, effective October 1, 2012.
- b. 580-5-33-13 requires that the organization has a system of internal monitoring that measures compliance with basic assurances and is designed to enhance quality.
 - The organization monitors Basic Assurances®.
 - A comprehensive plan describes the methods and procedures for monitoring Basic Assurances®.
 - C. Basic Assurances® monitoring data is used for continuous learning and improvement.

2. QDDP Training

- a. The Council on Quality and Leadership has developed these 9 training modules for human service providers in Alabama, in partnership with the Alabama Department of Mental Health/Division Developmental Disabilities. The curriculum can be accessed at <https://c-q-l.org/ALtraining>

- QDDP Overview
- Health, Safety, and Medical
- Overview of Assessments
- Know Your Rights
- Nurse Delegation
- Person-Centered Planning
- Administrative Code
- Incident Prevention and Management System
- Behavioral Support Planning

3. Teaching Methods

- a. Provides an overview of the assessments used in person-centered planning, identifies learning, participation and service opportunities, and teaching methods for development of person-centered plans.

4. Incident Prevention and Management System

- a. Falls
- b. Medication Errors
- c. Abuse
- d. Neglect
- e. Exploitation
- f. Intimacy and Personal Relationships

5. Fatal Five

- a. Aspiration
- b. Bowel Obstruction
- c. GERD
- d. Seizures
- e. Infection/Sepsis

For additional training offerings, please see the Procedural Guidelines for Personal Outcome Measures and Person-Centered Thinking.

As an ongoing quality improvement initiative, the regional QE staff will identify trends through the review of quarterly incident reports that are submitted in Therap. Additional trends will be noted through routine monitoring conducted by regional community services staff. Finally, QE staff will have an opportunity to identify trends by conducting in-person Personal Outcome Measure (POM) interviews with people receiving services and the organizations that support those people and by attending certification exit meetings.

Based on training and TA needs, QE staff may announce services to community providers individually or collectively. Provider may also contact QE staff upon request to receive training and technical assistance. To request technical assistance or training, please contact the Quality Enhancement Specialist in your region:

Patricia Bailey, Region I Quality Enhancement Region I Community Services

Phone: (256) 552-3712
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CHAPTER 7

BEHAVIORAL SERVICES

7.1. Behavioral Services Procedural Guidelines

Responsible Office: Psychological and Behavioral Services

Reference: ADMH Administrative Code 580-5-33-.02 (15), Behavioral Service Procedural Guidelines: DDD-PBS, HCBS Waivers

Statement: The Behavioral Service Procedural Guidelines were established to provide behavioral services for persons with intellectual disabilities in the state of Alabama. The guidelines were developed by the Behavior Analysis Task Force, a group of professionals representing both community providers and the Developmental Disabilities Division of the Department of Mental Health. The guidelines were developed using the principles of Applied Behavior Analysis as the foundation. Behavioral services based upon these principles have resulted in successful skill acquisition and/or behavior reduction for persons with intellectual disabilities. Because of the evidence-based support for the use of a behavior analytic approach to the provision of behavioral services, the state of Alabama Department of Mental Health determined that services based on these principles would provide the best quality for the consumers served.

Purpose/Intent: The purpose of the guidelines is to provide information and guidance for the development and implementation of behavioral services for persons with intellectual disabilities who are receiving services through one of the community agencies contracting with the state Department of Mental Health. The guidelines are intended to supplement the Community Standards used for certification of service agencies.

Scope: These procedures apply to all providers and recipients of behavioral support services through the Alabama Department of Mental Health, Division of Developmental Disabilities.

Definitions: The Behavioral Guidelines describe all of the behavioral training and intervention strategies that are approved for use in the state of Alabama. The term *behavioral* refers to interventions that focus on actual, measurable, real-world behaviors and outcomes; HRC (Human Rights Committee); BPRC (Behavior Program Review Committee); IDT (Interdisciplinary Team); BSP (Behavior Support Plan)

Procedures:

1. The Behavioral Services Procedural Guidelines outline the minimum requirements for providing behavioral services in the state of Alabama.
2. The Behavioral Services Procedural Guidelines details four levels of procedures in providing an individual with each successive level indicative of greater restrictiveness, such that Level 1 procedures are not restrictive at all and Level 4 is highly restrictive. All level 4 procedures must be approved by the Director of Psychological and Behavioral Services, only after the Person-Centered Plan and BSP have been reviewed by the IDT, individual, HRC, and BPRC.
3. The Behavioral Services Procedural Guidelines require that, for any person prescribed psychotropic or other medications for the purposes of addressing/treating behavioral challenges and/or psychiatric symptoms, a Psychotropic Medication plan be developed for the purposes of ensuring that reductions are considered and implemented wherever possible.
4. Anyone providing behavioral support services, as well as positive behavior supports through ADMH- HCBS waiver services must have received training on the Behavioral Services Guidelines provided by the Office of Psychological and Behavioral Services.
5. The Office of Psychological and Behavioral Services provides the Behavioral Service Procedural Guidelines Training throughout the five ADMH-DD regions.
6. Requests for training can be made through the three Comprehensive Support Teams, as well as through the Director of Psychological and Behavioral Services.

7.2. Special Level of Staffing Restrictions

Responsible Office: Regional Community Services

Reference:

Statement: Special level of staffing is a restriction requested via the Request for Action process that must be justified with data and documentation and managed as per Behavioral Guidelines.

Purpose/Intent: As an intrusive restriction, special level of staffing must be requested in accompaniment with, at a minimum, relevant target behavior data, Behavior Support Plans, and review/rationale from the person's interdisciplinary team.

Scope: Regional Community Services; Fiscal Manager; Service Coordinators; Providers

Definitions: Regional Community Services (RCS); RFA (Request for Action); Community Services Specialist (CSS); GER (General Event Report); BSP (Behavior Support Plan); IRBI (Individual Residential Budgeting Instrument); DDD IMS (Division of Developmental Disabilities Information Management System)

Procedures:

1. If a person served requires a special level of staffing restriction, the Provider submits to the Support Coordinator a Request for Action (RFA) detailing the special level of staffing restriction requested and provides (at minimum) the following documentation:
 - a. If requesting supports for behavioral concerns:
 - i. Current Behavior Support Plan, including a realistic and attainable plan for fading of special level of staffing restriction and all required approvals
 - ii. Target behavior frequency data in line graph format (as applicable) for the previous three (3) months (if an initial restriction) or for the previous twelve (12) months (if a continuation of a restriction).
 - Data on fading periods (if applicable)
 - When the Behavior Support Plan utilizes any type of protective equipment as a means to reduce behavior, data will be submitted on the use of protective equipment (i.e. number of times used and duration of application)
 - When staffing is utilized 24 hours/day, data will be submitted on hours slept per night and behaviors that occur during overnight hours separate from behavior frequency data
 - The most recent Quarterly Support Coordinator Summary
 - iii. Interdisciplinary team note reflecting:
 - Review of necessity of continuing special level of staffing restriction
 - Rationale for continuing special level of staffing restriction, if continued
 - Review of the effectiveness of the BSP
 - Review of progress on alternatives to targeted behaviors justifying the use of special level of staffing
 - Recommendations for modifying the BSP to better address target behavior(s) warranting the special restriction, if deemed ineffective at reducing frequency(s) of target behaviors
 - b. If requesting supports for medical concerns:
 - i. Detail of supports individual requires due to medical status
 - ii. Most recent physical/medical assessment
 - iii. Current status (i.e. progression, regression, or no change)
2. The Support Coordinator uploads these documents to DDD IMS Notes and tags designated RCS staff responsible for managing RFA's.
3. RCS reviews the RFA and associated documentation for completeness and compliance with Behavioral Guidelines.
4. If questions or incomplete/insufficient documentation, RCS responds to the Support Coordinator to request additional information.

5. The Support Coordinator communicates with the Provider to obtain the requested information.
6. When providers do not provide documentation to substantiate the need for a staff-involved restriction (e.g., special level of staffing), RCS cannot authorize billing based on an IRBI that reflects that special level of staffing.
 - a. When this occurs, RCS will offer non-compliant providers the option of submitting an IRBI updated to reflect standard level of staffing for persons for which special level of staffing documentation has not been adequately submitted. Thus, they may bill uninterrupted and may then later back-bill for the difference in the special level of staffing rate once they come into compliance.
7. Upon receipt of all available/requested information and within seven (7) working days, RCS makes a determination based on individual progress and factors in data/BSP (e.g., data trends, fading criteria, etc.) and on Behavioral Guidelines.
8. A final determination is communicated to the Support Coordinator via DDD IMS Notes.
9. The Support Coordinator communicates this determination to the Provider within three (3) working days.

7.3. Comprehensive Support Systems (CSS) Teams

Responsible Office: Psychological and Behavioral Services

Reference: ADMH Administrative Code 580-5-30-.02 (2); ADMH Policy 540-1

Statement: The Alabama DMH Division of Developmental Disabilities (DD) provides a comprehensive array of specialized services for people with intellectual disabilities in the State of Alabama who meet criteria for services through an interdisciplinary treatment modality, utilizing clinical professionals with advanced training in behavioral support services.

Purpose/Intent: The Comprehensive Support Services teams were established to provide consultative assistance to agencies, organizations, and communities to address significantly challenging, crisis, and/or emergency situations that may lead an individual with an intellectual disability to psychiatric hospital admission, incarceration, or difficulty maintaining community placement. Specialized services, consultations, evaluations, and training services are provided in a manner that is designed to increase the capacity and expertise of agency, organization personnel, and/or family serving the individual, as well as to assist the person.

Scope: These procedures apply to all that provide services and supports to people with intellectual and developmental disabilities through ADMH-DD.

Definitions: Individuals Served: Persons who meet the criteria of having an Intellectual disability and present issues which require diagnostic or treatment consultation may be eligible for services provided by the Comprehensive Support Services teams.

Procedures:

1. Comprehensive Support Services teams assess the need for and assist with providing an array of supports to individuals who require specialized services. Additionally, these teams assist providers with developing internal capacity related to these and other specialty areas.
2. The three Comprehensive Support Services teams are located in Decatur, Montgomery, and Mobile, and have offices located in the Regional Community Services offices. The division of responsibilities for state-wide coverage is as follows:
 - Decatur team - provides services for Regions I and upper part of Region II;
 - Montgomery team - provides services for Regions IV and V; and
 - Mobile team - provides services for Region III and lower part of Region II.
3. Comprehensive Support Services team consist of a licensed advanced level psychology professional who serves as the team leader and is responsible for coordinating the development and maintenance of procedures and protocols (standardized across teams) addressing all activities of the team, including the intake process; Master's and Bachelor's level psychological and behavioral services professionals; and, a clinical professional specialized in providing behavioral services to children. CSS will also utilize the services of a Primary Care Physician; a Psychiatrist; a Dentist via contract consultation and part-time employment opportunities.
4. Services Provided:
 - a. Training on the Behavioral Services Procedural Guidelines
 - b. Consultation regarding individuals with severe behavioral problems
 - c. Assistance with developing Behavioral Support Plans, Special Level of Staff Plans, Fading Plans
 - d. Activities in the areas of psychiatric consultation services, medical consultation services, and dental services may require the participation of multiple team specialists.
5. Who should be referred:
 - a. Person with ID who exhibits challenging behaviors with the potential to escalate into a crisis situation
 - b. Medical, psychiatric, or dental services cannot be obtained in the community for the person
 - c. Current behavioral or medical treatment strategies are not effective
 - d. Numerous psychotropic medications or high doses are prescribed

- e. Person begins exhibiting new problem behavior(s)
 - f. Recent psychiatric/behavioral hospitalization(s)
 - g. Involvement with law enforcement due to behavioral disturbance
6. Accessing Services: In order to access Comprehensive Support Services, provider agencies and/or families should contact their Regional Community Services Office. The Directors of these offices implement established procedures for processing and prioritizing referrals using the Request for Regional Action procedures.

CHAPTER 8

WAIVER SERVICES

8.1. IRBIs

8.1.a. For DMH and DHR Funded School Aged Children

Responsible Office: Administrative and Fiscal Operations

Reference: N/A

Statement: Calculating residential rates for school aged children on the ID waiver and matched with DMH or DHR funds

Purpose/Intent: Blended rates of school days and out of school days have been used in the past to calculate an annual IRBI rate. When this is done, and a student's residence changes during the school year, this results in the provider reimbursement being incorrectly reflective of the student's school versus home hours.

Scope: School aged DMH and DHR in residential waiver services

Definitions: IRBI (individualized residential budgeting instrument); DMH (Department of Mental Health); DHR (Department of Human Resources); ID (intellectual disabilities)

Procedures: When calculating residential rates for school aged children you should formulate two IRBIs. One for the school year and one for the summer break. When authorizing these rates for billing purposes the school year calendar of the system the student is attending should be reviewed for school year ending and beginning dates.

8.1.b. Absentee Rates

Responsible Office: Administrative and Fiscal Operations

Reference: N/A

Statement: Calculation of Absentee Rates for the IRBI

Purpose/Intent: To establish eligible dates for calculating individual residential absentee rates.

Scope: This guideline applies to all providers of residential services and fiscal managers representing ADMH/DDD regional offices.

Definitions: IRBI (individualized residential budgeting instrument)

Procedures: Providers are allowed to change existing residential absentee rates on the IRBI once a year in the month of August to be reflected on the authorizations beginning September 1st. Changes in absentee rates should be requested directly to the Fiscal Manager representing the region of the individual's residence.

8.2. Housing Specialist Access Request

Responsible Office: Regional Community Services

Reference: Administrative Code 580-5-33-.02 (21)

Statement: A Housing Specialist is assigned to each Regional Community Services Office.

Purpose/Intent: The Housing Specialist assists persons served on the Waiver with obtaining safe and adequate housing by guiding them through, and facilitating resolution of, the bureaucratic and financial processes involved.

Scope: Housing Specialist; Director of Community Programs; Regional Community Services; Support Coordinator

Definitions: RFA (Request for Action); IDT (Interdisciplinary Team); PCP (Person-Centered-Planning)

Procedures:

1. Notification is received via the Regional Office monitoring process, direct Support Coordinator referral, or the RFA process, that an individual is interested in obtaining housing.
2. The Housing Specialist attends the IDT meeting and/or PCP meeting in order to identify the individual's strengths and any barriers to housing stability and develops strategies to overcome these barriers.
3. The Housing Specialist takes the lead in coordinating the process of application, referral, contact with the Benefits Specialist and current Provider, while collaborating with the Support Coordinator.
4. Once housing placement is achieved, the Housing Specialist continues to provide mediation and advocacy along with educating the individual on tenant rights and responsibilities to promote successful community living.
 - a. The duration and content of this ongoing support will be based on identified needs of the person and included specifically in their Person-Centered Plan.

8.3. SUPPORTED EMPLOYMENT

8.3.1. Discovery Assessment/Profile

Responsible Office: Office of Employment Services

Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-33-.02 (6) (2); Medicaid Administrative Code

Statement: Employment should be a first option for people receiving waiver services.

Purpose/Intent: DD Waiver services should be utilized to assist individuals with obtaining and maintaining employment

Scope: Support Coordinators, Providers, Families

Definitions: Discovery: A period of exploration to explore skills, interest, talents and abilities.

Procedures: A community-based assessment to develop a profile to pursue competitive employment.

Discovery/Assessment is limited to no more than ninety (90) days and should not overlap other services and is available for individual participants interested in employment. The expectation is that much of the process be performed outside of a facility and off the grounds of the facility. The Discovery process should be individualized.

Discovery shall be limited to no more than 100 units (25 hours) of service. The provider shall document each date of service, the activities performed that day, and the duration of each activity completed. Reimbursement for discovery/assessment should be billed at three distinct intervals during the process.

The first billing for services occurs after one third, no more than 8 hours or 32 units, of the discovery/assessment process and requires documentation of activities performed that support the billing during the first period of the assessment process.

The second billing for services occurs at the two thirds, no more than 8 hours or 32 units, of discovery/assessment process and requires documentation of activities performed that support the billing during the second period of the assessment process.

The information developed through Discovery allows for activities of typical life to be translated into possibilities for integrated employment. Discovery results in the production of a detailed written Profile summarizing the process, learning and recommendations for next steps. The written Profile is due no later than ninety (90) days after the service commences.

The final payment for discovery/assessment is billed after the completion of the report and can include no more than 9 hours or 36 units of service. This service is limited to two assessments per each waiver participant, with the second assessment being conducted only if the participant changes service providers. To exceed the capped amount, documented justification should be sent to the Employment Coordinator at the Central Office, or the Employment Specialist at the Regional office.

Approvals will then follow the established request for service procedures. No waiver participant can receive more than four discovery/assessment services over the lifetime of the waiver.

Participation in Pre-Vocational services is not a requirement for Discovery. If the same agency that completes the Discovery is also the agency that provides other employment services, i.e. job development, job coaching, etc., VR should not be billed for an additional Discovery service.

8.3.2. Pre-Vocational Services- Pathway to Employment

Approved by Associate Commissioner:

Responsible Office: Office of Employment Services

Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-33-.02 (5); Medicaid Administrative Code

Statement: Individuals receiving prevocational services must have employment-related goals in their Person-Centered Plan

Purpose/Intent: Prevocational services are utilized to prepare an individual for paid or unpaid employment and are not job-task oriented, but instead aimed at a generalized result.

Scope: Support Coordinators, Providers, Individuals, Families

Definitions: A generalized service that helps an individual progress down a defined pathway to employment. Only individuals interested in integrated and competitive employment should receive this service.

Procedures: The Prevocational habilitation service under the Waiver is designed to create a path to integrated, competitive employment in which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Pre-vocational services include teaching such concepts as attendance, task completion, problem solving, interpersonal relations and safety, as outlined in the individual's person-centered plan. Prevocational services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task specific strengths and skills that contribute to employability in paid employment in integrated community settings. Pre-vocational services should occur as much as possible outside the facility and off the grounds of the agency. A best practice would include a minimum of 50% of the service occurring in the community.

Services are expected to occur within a period **not to exceed 2740 units**, with employment (integrated and competitive salary/wage) being the specific outcome. A pre-vocational unit is defined as one hour.

During participation in pre-vocational services, the expectation is that a referral will be made to the Alabama Department of Rehabilitation Services/VR when the individual is ready to move forward with obtaining a competitive job.

If, after the 2740 hours of service, a person has not been referred to ADRS, obtained competitive employment or moved into other waiver services, the provider **must** justify why additional Prevocational habilitation services would be beneficial to continue the individual on a "pathway to employment". The request for continuing this service must be made in writing, along with supporting documentation to the Office of Supported Employment in the Central Office or to the designated Employment Specialist working in the Regional Office. The Employment Coordinator and/or Employment Specialists will review the request and notify the Support Coordinator of the decision to approve or deny the request. If approved, the Support Coordinator will begin the RFA process to the Regional Office.

Individuals receiving prevocational services must have employment-related goals in their Person-Centered Plan; the general habilitation activities must be designed to support such employment goals. **If the beneficiaries are compensated, they are compensated at less than 50 percent of the minimum wage;** 42CFR 440.180 (c) (2) (i)

Participation in prevocational habilitation services **is not** a required pre-requisite for individual or small group supported employment services under the waiver.

8.3.3. Vocational Rehabilitation

Responsible Office: Office of Employment Services

Reference: ID and LAH Waivers; Medicaid Administrative Code

Statement: Individuals that express interest in competitive integrated employment should be referred to the Alabama Department of Rehabilitation Services (ADRS), Vocational Rehabilitation (VR).

Purpose/Intent: VR is funded by the Rehabilitation Act of 1973 or P.L. 94-142. These services should be accessed prior to waiver funding for supported employment services.

Scope: Support Coordinators, Providers, Individuals, Families

Definitions: Supported employment (SE) services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that: A generalized service that helps an individual progress down a defined pathway to employment. Only individuals interested in integrated and competitive integrated employment should be referred to VR.

Procedures: Vocational Rehabilitation Service (VRS), the largest division within the Alabama Department of Rehabilitation Services that assists Alabamians with disabilities achieve independence through employment.

VR provides specialized employment- and education-related services and training to assist teens and adults with disabilities in becoming employed.

The types of services available through VR are varied and designed specifically to meet the needs of each individual. Available through any of the 20 VRS offices statewide, services can include pre-employment services, transition services, educational services; vocational assessments and evaluations, guidance and counseling; job training; assistive technology; orientation and mobility training; and job placement and retention.

To be eligible for services, individuals must have a physical or mental impairment which results in a substantial barrier to employment, and there must be a reasonable expectation that he or she can benefit from rehabilitation services in terms of becoming employed.

To determine the appropriate VR office in your area, please visit www.rehab.alabama.gov and click on office locations.

When an individual receiving ADMH funded waiver supports expresses interest in competitive employment, the plan to support this goal should include a referral to VR. There are several steps that should be taken to ensure the appropriate referral process is followed, along with making sure the individual is interested in competitive integrated employment.

1. Once an individual expresses interest in working in competitive employment, an initial “Discovery” assessment should be provided. The Discovery process is an evidence-based alternative to comparative, standardized assessments, and evaluations completed by a qualified employment supervisor professional. Discovery is a person-centered planning process that involves getting to know a person before supporting them in developing a plan for employment. (See Operational Guideline 5.2 for more information on Discovery)
2. Once the Discovery assessment is complete and the individual continues to express interest in working, additional steps should be taken to assist the individual. These steps include:
 - a. A meeting held with the individual to complete benefits planning. The benefits planning can be provided by either the ADMH funded Community Work Incentives Coordinator or a provider agency with an “approved and certified” benefits planner. (See operational Guideline 5.1 for more information on Benefits Planning).

- b. A meeting either in person or via conference call should be held with the individual and team which may include provider agencies, the support coordinator, family members, etc. During this meeting, the plan for work is finalized so an appropriate referral to VR is made.
 - Transportation options should be discussed so that once the employment goal is achieved, the individual encounters no difficulty getting to and from work.
 - A determination is made regarding the individual/agency responsible for assisting with ongoing benefits reporting. (See operational guideline 5.1 for more information on benefits reporting).
 - Contact should be made with the local VR office and an appointment scheduled so individual can officially apply for VR services.
 - A release form should be signed by the individual to grant permission for referring agencies (day and/or residential, support coordinator, etc.) to provide records to VR to determine eligibility. This release form should also grant permission for VR to discuss eligibility, need for additional information, etc. with the service coordinator or whoever the individual chooses. With provision of appropriate records, eligibility should be determined within 60 days. *See Alabama Department of Mental Health Alabama Department of Rehabilitation Services Authorization/Consent for Use or Disclosure*
 - c. Once an individual is determined eligible for VR services, the ADRS Counselor will refer the individual to an authorized supported employment service provider (funded by ADRS utilizing a Milestones payment system). The service provider will complete the following milestones:
 - Determination of Need: 2 Situational Assessments, PCP (vocational) Plan, or the Discovery Profile. (Milestone I/Discovery/PCP) should not be needed if agency has completed the Discovery utilizing Waiver funding).
 - Hire: The individual is placed into competitive employment and completes 3 days on the job.
 - Job Retention: The individual receives onsite job coaching to ensure that satisfactory job performance is achieved to maintain employment.
 - Closure: After initial job coaching (retention services) is provided to achieve stabilization, VR will provide an additional 90 days of post stabilization follow up. Once the 90 days are complete, the VR case is closed as successfully rehabilitated (employed).
 - d. Waiver services should be utilized throughout this process to support the individual working in competitive employment. Services that could be utilized to support long-term needs include:
 - Ongoing benefits planning and/or reporting services
 - Personal Care and/or Personal Care at the Worksite
 - Employment Transportation
 - Job Coaching
3. If VR determines that an individual isn't eligible for services for any reason, waiver support can be utilized to provide the job developer service. (Please see Operational Guideline 5.4 for more information on job developer).
- a. If the VR counselor, after trial work experiences determines that the consumer cannot benefit from SE services, or that SE services are not available in their area, VR should provide a letter explaining

the findings and this should be provided to ADMH provider. This documentation allows an ADMH agency to provide supported employment under the waiver.

- b. If VR fails to provide a written statement regarding ineligibility, the support coordinator, provider agency, etc. should document the efforts that were made to access VR services. This documentation should include the dates the individual met with the VR Counselor, the name of the VR Counselor, any verbal feedback that was provided by VR to the individual or referring agency or support coordinator, etc. This documentation should be included in the individuals file that confirms that reasonable attempts were made to access VR prior to utilizing any waiver funds. If individual refuses to pursue VR services (choice) this should also be clearly documented in the file. Reasons for refusal should be detailed.

8.3.4. Individual Supported Employment Services

8.3.4.a. Job Developer

Responsible Office: Office of Employment Services

Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-33-.02 (6) C; Medicaid Administrative Code

Statement: A distinct service that supports Individualized Supported Employment – Job Developer.

Purpose/Intent: Job developer services are available to support an individual in obtaining integrated, competitive employment.

Scope: Support Coordinators, Providers, Individuals, Families

Definitions: A distinct service that is utilized to help an individual obtain a job. This supported employment service is not available to recipients eligible for benefits under a program funded by either Section 110 of the Rehabilitation Act of 1973, or P.L. 94-142.

Procedures: When an individual expresses interest in obtaining a job, a referral should be made to the Alabama Department of Rehabilitation Services (VR). Once the referral is made to VR, the individual, along with the Support Coordinator and/or service provider should maintain contact with the VR Counselor to ensure follow through with eligibility determination. This VR eligibility determination should be made as soon as possible, but no later than 60 days from the initial application date. The individual is encouraged to provide a signed release to VR, so the VR Counselor can speak with the Service Coordinator and/or provider agency representative if necessary for additional information and/or monitor progress towards eligibility determination. Historically, VR has been hesitant to speak with anyone other than the individual due to HIPAA regulations.

If deemed eligible by VR, the individual is expected to receive the job development service which is necessary for competitive and integrated employment. However, if VR determines that individual does not meet eligibility criteria or services through VR are otherwise not available, the Job Developer service is available through the Waiver.

The Individualized Job Developer primarily markets the supported employment service and the person's skills with potential employer(s). This might include employer negotiation related to waiver recipient's skills, negotiating hours or location to meet needs of the waiver recipient, job carving, job placement, etc. Often the job developer will be out in the community performing the activities with or without the waiver recipient.

This Job Developer service will be limited to 40 hours per year. An employment plan is required initially, and subsequent updates can request modifications to the above limitations based on the observations of the professionals involved and approved by the RO Employment Specialist/Coordinator.

Training Requirements: A job developer must complete an ADMH approved training curriculum. Examples of approved curriculums include the bi-annual Customized/Supported Employment training taught by consultants

from Virginia Commonwealth University, or an approved web-based certification available through such entities as ACRE, Griffin Hammis, etc. Please contact the Office of Supported Employment with any questions related to approved certifications.

8.3.4.b. Job Coach

Responsible Office: Office of Employment Services

Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-33-.02 (6) C; Medicaid Administrative Code

Statement: A distinct service to support individuals at worksite – Job Coach

Purpose/Intent: The job coach service is provided to teach skills and provide support at a worksite to enable individuals to achieve the highest level of independence possible.

Scope: Support Coordinators, Providers, Individuals, Families

Definitions: A service that is utilized to teach job skills for competitive integrated employment and provide long term supports and follow up for job retention. This service if, furnished under the waiver, is not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Procedures: The job coach works directly with an individual that desires to work in competitive integrated employment. The minimal requirement for an individual providing the job coach service is graduation from high school or its equivalent and two years of work experience. A Bachelor's Degree with a major concentration in rehabilitation, industrial arts, vocational education, psychology or a related field is preferred. Work experience of a supervisory or training nature as well as knowledge of persons with disabilities would be particularly desirable.

The job coach service covers a variety of assistance that supports an individual in obtaining and maintaining employment. The hours worked by the job coach must be flexible to meet needs as they arise. The amount of job coach support will depend on the needs of the individual being supported, which will also influence the number of job coaching hours that should be authorized. It is expected that the job coach will fade his or her support as the individual becomes more integrated into the employer's workforce and grasps work tasks. It is also acceptable to supplant some of the job coach's faded hours thorough the utilization of personal care at the worksite. The overall goal of job coaching is to develop independence at the worksite

Overall, the Job Coach is responsible to the Program Director for the training and associated support services necessary to ensure the success for individuals involved in Supported Employment. These services might include:

1. Completion of job analysis's and/or task analysis's through employer interviews, actual job performance to insure a thorough understanding of the specific job and general job rules prior to placement of the individual;
2. Teaching work skills/tasks, responsibilities and behaviors not related to the specific job being performed, such as how to complete a time card, when and where to take bathroom and lunch breaks;
3. Ensuring that each individual placed into employment receives the necessary support to become an integrated member of the work force. This may happen in the general course of the job but could require activity such as encouragement of the individual worker or other employees to communicate with each other, or the provision of disability awareness training to workers of the company;
4. Working with the individual to be placed in employment and/or with family or service provider to ensure that the individual has reliable transportation to and from work, adequate housing, and emotional support for his or her job efforts
5. Making every effort to ensure that the individual in supported employment is matched to an appropriate job using a comprehensive vocational assessment (Situational Assessment and/or Discovery) prior to job

- placement. Part of the assessment may include reviewing current progress notes in individual's present placement, studying referral information, and working with the individual to assess work skills;
6. Communicating through written and oral reports on the progress of individual's in supported employment to the Program Director and other program staff; follow oral or written instructions (such as the care plan or rehabilitation plan);
 7. Providing continued ongoing support to individual's in supported employment'
 8. Performing other job duties necessary to ensure the success of individual's in supported employment as well as any additional tasks assigned by the Program Director that will be of benefit to other individuals in the program.
 9. Facilitating job accommodations and use of assistive technology
 10. Educating the person and others on the job site regarding rights and responsibilities and the role of self-advocacy in the work place.

Individuals providing job coaching services should complete the ADMH recognized training on customized/supported employment. Currently, the 3-day certificate-based training taught by consultants from Virginia Commonwealth University is recommended. Other curriculums must be approved by the ADMH Office of Employment Services.

8.3.5. Supported Employment Small Group

Responsible Office: Office of Employment Services

Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-33-.02 (6) b; Medicaid Administrative Code

Statement: Services and training activities provided in a regular business or industry in community settings for groups of two (2) to eight (8) workers.

Purpose/Intent: This intent of this service is sustained paid employment and work experience leading to further career development and community-based individualized employment.

Scope: Support Coordinators, Providers, Individuals, Families, Regional Community Service Offices

Definitions: Service that teaches job skills to a workgroup such as mobile work crews and other business-based workgroups employing small group of workers. The goal of this service is to develop skills that lead to individualized competitive employment in the community. This service is not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Procedures: Supported Employment Small Group must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience that leads to further career development and community-based employment for which the compensation is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

The supported employment small group works in community-based integrated settings in groups from two (2) to eight (8) workers. This service should not occur in facility-based settings or other similar types of vocational settings that are not part of the general workplace. These workgroups should only perform work in integrated community-based settings with competitive wages.

Supported Employment Small Group providers must meet the same standards as Day Habilitation providers. The staffing pattern should be appropriate to the type and scope of program services and should include staff members who meet the experience and educational qualifications set forth in the job coaching service. No individual in this service should ever be left unsupervised unless the activity is part of a structured activity outlined in the person-centered plan.

8.3.6. Transportation

Responsible Office: Office of Employment Services

Reference: ID and LAH Waivers; ADMH Administrative Code; Medicaid Administrative Code

Statement: Service that provides waiver participants access to and from their place of employment in the event the support team is unable to facilitate transportation through other means.

Purpose/Intent: The intent of this service is to ensure an individual has transportation to and from their place of employment. This service should only be accessed when other means of transportation cannot be identified or facilitated.

Scope: Support Coordinators, Providers, Individuals, Families, Regional Community Service Offices

Definitions: Employment transportation is the provision of service to permit waiver participants access to and from their place of employment in the event the support team is unable to arrange alternate means of transportation to and from work. The provision of this service must be necessary to support the person in work related travel and cannot be reimbursed for merely transportation. This service is not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Procedures: Employment transportation is a distinct service to transport an individual to and from an integrated competitive employment setting. The team's efforts to secure transportation must be documented in the case record. This service shall not duplicate or replace the Medicaid non-emergency medical transportation program. This does not preclude other arrangements such as transportation by family or friends. It is the expectation that as part of the person-centered planning process and employment outcomes, long term transportation to and from the worksite will be facilitated and arranged.

Payment for this service will be reimbursed based on the IRS mileage rate and required documentation (i.e. vendor receipt or travel log) of service by the mile. This unit of service is a mile. Documentation should also include progress toward obtaining long term transportation as part of measuring the employment outcomes.

Transportation must be provided by public carriers (i.e. charter bus or metro transit bus) or private carriers (i.e. taxicab). Commercial transportation, including day or residential provider agencies – must have a business license. All drivers must have a valid driver's license of appropriate type (i.e. commercial) for transport in Alabama. Also, all vehicles transporting individuals must have insurance as required by law. The agency employing any driver should ensure that the driver has a good driving record and receives in-service training on safety procedures when transporting an individual.

This service shall not replace transportation that is already reimbursable under day or residential habilitation. This service is reserved for only those waiver participants who are employed. The planning team must also assure the most cost-effective means of transportation, which would include public transport when available. Employment transportation is not intended to replace generic transportation or to be used merely for convenience.

8.3.7. Benefits Planning and Reporting

Responsible Office: Office of Employment Services

Reference: ID and LAH Waivers; ADMH Administrative Code 580-5-33-.02 (18); Medicaid Administrative Code

Statement: Employment should be a first option for people receiving waiver services.

Purpose/Intent: Benefits Planning and Reporting Services should be utilized to help people manage benefits when pursuing and obtaining employment.

Scope: Support Coordinators, Providers, Families

Definitions: Benefits Planning and Reporting Services enable individuals to work while maintaining needed Social Security and medical benefits.

Procedures: An individual wishing to pursue employment should be referred for benefits planning and reporting services. This can be provided either by an ADMH funded CWIC (Community Work Incentive Coordinator employed through ADRS) or by the provider agency.

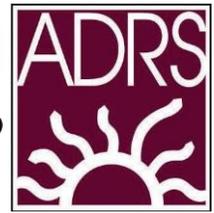
1. The Alabama Department of Mental Health contracts with the Alabama Department of Rehabilitation Services to provide CWIC coverage in the 5 DD regions. To access the ADMH/ADRS CWIC service, please:
 - a. The agency maintains a toll-free number available statewide for any individual to make self-referrals or for partners to make phone referrals on a beneficiary behalf. Once the referrals are made, a determination is made regarding which program will serve that individual. **Toll-Free phone referral: 877-816-4602**
 - b. **Internal VR referrals (SMILE):**
Referrals can also be made through internal means. If an individual has a VR counselor, the VR counselor and their support staff are encouraged to make that referral directly through the internal case management system-SMILE. This process speeds up the referral process and allows us to monitor and manage those referrals more efficiently.
 - c. **DMH/partner paper referrals:**
Referrals are also received directly from DMH regional staff, providers and other partners by completing a basic form. Copies of the referral forms are systematically sent to regional staff. A copy of that form is attached.
2. Provider agencies may offer these services directly and receive waiver reimbursement if:
 1. For benefits planning, the agency must employ a credentialed staff member. This credentialing requires completion of either a national recognize Community Work Incentive Coordinator training or web-based Work Incentives Planning and Utilization for Benefit Practitioners Certificate Series offered through Cornell University. The benefits planning is capped at 60 Units per individual. (15-minute units)
 2. For benefits reporting, the agency must employ a staff member that meets requirements outlined in (a) above or have a staff member that has participated in a Social Security Work Incentives boot camp available through ADRS -CWICs. ADMH Regional Employment Specialists can help arrange this training session. A *certificate of completion* is necessary and should be provided to Support Coordination agency and others approving RFAs. The benefits reporting is capped at 144 Units per individual. (15-minute units).
- 3.

Please Note: Benefits reporting should only be provided and billed on individuals earning more than \$85.00 per month. SSI recipients automatically qualify for an \$85.00 Earned Income Exclusion so wage reporting wouldn't be necessary. For more information about work incentives visit: www.ssa.gov/disabilityresearch/workincentives.htm and www.ssa.gov/redbook.

4. The agency providing this service should provide copies of individual's check stubs when requesting these services be added to the RFA to confirm both employment and wages.
5. Documentation of provided service(s) should be maintained in individual's file.
6. Reporting should be provided to individuals to avoid any overpayment or jeopardize loss of benefits and medical coverage



DMH/ADRS Benefits Counseling Project



A cooperative agreement between DMH and ADRS. Trained, certified staff provide benefits counseling services to individuals currently on ID (Intellectual Disabilities) or LAH (Living at Home) waivers or on a wait list for either waiver. The targeted population for this service includes individuals with THE MOST SEVERE disabilities with NO paid employment history, sheltered employment (sub-minimum wage), or other competitive employment.

Criteria For Referral:

- Individual receiving SSI or SSDI due to a disabling condition (no auxiliary or retirement recipients)
- Currently on the ID or LAH Waiver or on the wait list for either waiver
- Considering employment, or has employment as a goal

What can Benefits Specialists Do?

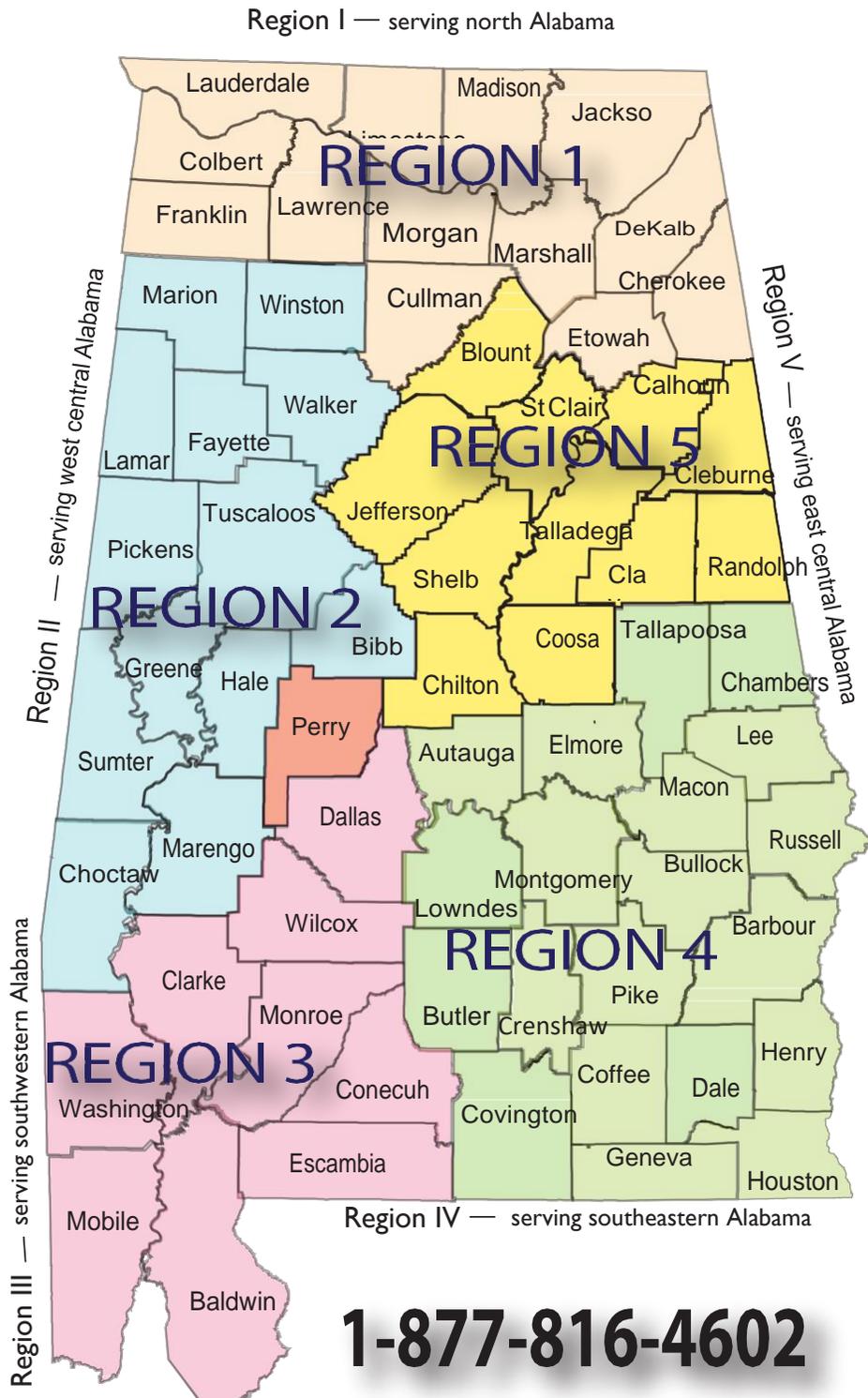
- Verify cash benefit type, amount and health care coverage
- Provide guidance on the impact of paid wages on cash and health care
- Develop, monitor and help maintain work incentives while an individual is working
 - May in some situations assist with addressing any overpayment concerns (as long as it involves work)

What can Benefits Specialists NOT Do?

- Cannot assist with applications for SSDI/SSI
- Cannot assist with waivers or appeals
 - Cannot serve as non-legal representative to SSA

How Can an Individual Receive Services?

- A person with a disability or their family member can contact the toll free number (located in Montgomery) and make a telephone referral
- A professional (case manager, service provider, employment provider, VR counselor etc.) can make a referral



1-877-816-4602

Referral form can be found on the opposite side of this flyer.



Benefits Planning Referral-DMH

About the Beneficiary/Recipient

***Required Information—referrals submitted without required information will not be processed.**

*Participant Name:		Date of Referral:	
*Address:(Street, City, Zip)			
*County:			
*Primary Phone:		Alternate Phone:	
*Ethnicity:	<input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other _____	*Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
*Other Benefits:		<input type="checkbox"/> Food Stamps <input type="checkbox"/> Subsidized Housing <input type="checkbox"/> Other: _____ (list)	
*SSN:	_____ - _____ - _____	*DOB:	____/____/____
*Waiver Type:	<input type="checkbox"/> LAH <input type="checkbox"/> ID <input type="checkbox"/> Other: _____	*If no waiver, waiver wait list:	Type: _____ ____/____/____ Date:
*SSDI Amount:	\$ _____	*SSI Amount:	\$ _____
*Primary Disability:			
Secondary/Other Disability(ies):			
<input type="checkbox"/> Representative Payee or <input type="checkbox"/> Guardian <input type="checkbox"/> N/A		Name/Phone: _____	

*About the Employment Status:

<input type="checkbox"/>	Currently employed or self employed	**If employed, Start Date: _____
	Employer Name:	Location:
	Hours per week:	Rate of Pay:
<input type="checkbox"/>	Job Offer Pending	
	Employer Name:	Location:
	Hours per week:	Rate of Pay:
<input type="checkbox"/>	Actively Seeking Employment	
<input type="checkbox"/>	Current ADRS consumer working within Supported Employment, Discovery, Search, Gate or other.	
<input type="checkbox"/>	Currently working with a different Employment Network provider (non ADRS)	
<input type="checkbox"/>	Currently seeking employment independently	
<input type="checkbox"/>	Not seeking employment, seeking information only (considering)	
Current Job Goal	Reason for referral:	

*Contact Information for Referral Source: (all required information)

Note: In the event further information/clarification is needed, COMPLETE and accurate referring agent information increases our ability to process all referrals in a timely manner.

Referring Agent Name	Organization Name
Address:	Referring Agent Phone () _____ - _____
Referring Agent Email Address:	
Referring Agent Position:	<input type="checkbox"/> Case Mgr <input type="checkbox"/> Residential Staff <input type="checkbox"/> Job Coach <input type="checkbox"/> Family/Parent/Guardian
If Parent/Guardian/Relative: Relationship <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Other: _____	

Contact Information for Others: (please provide ALL contact info –cell phone, email, office, etc.)

Send Referral Form to: Opal Thanem at Opal.Thanem@rehab.alabama.gov or fax to 334-293-7392.
Call 334-293-7244 to speak with Opal directly with any referral questions or to make a referral by phone.