
# Division of Developmental Disabilities (DDD)
# Provider Operational Guidelines Manual

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

Revised March 1, 2026

For previous publications visit our website at: https://mh.alabama.gov/provider-operational-guidelines-manual/

Letter from Associate Commissioner

March 1, 2026

Thank you for your participation with the Alabama Department of Mental Health's Division of Developmental Disabilities (ADMH-DDD) in serving individuals with intellectual and developmental disabilities. The provision of a service delivery system that is responsive to the needs of individuals with intellectual disabilities is a priority and continuous initiative for the ADMH-DDD. This updated version of the ADMH-DDD provider manual is evidence of this commitment as we seek to provide a statewide system of services and supports, that is efficient and effective in addressing the growing and changing needs of those we serve.

Alabama Administrative Code regulation 580-5-29.01 sets forth ADMH-DDD's authority and responsibility to establish reasonable rules, policies, procedures and other regulations that detail how we perform our various duties and responsibilities. The guidelines set forth in this manual specifically address procedures and other regulations for providers under contract with the ADMH-DDD, describing how providers interact with the ADMH-DDD in providing various services and supports. Note that this manual will continue to evolve and be updated to reflect our progress in developing a comprehensive service delivery system.

We look forward to future work around these and other guidelines that are based on stakeholder engagement and evaluation of the ADMH-DDD service delivery system.

Sincerely,

Camille Cumuze

Camille Cumuze
Associate Commissioner, ADMH-DDD

# Process for Reviewing and Updating the Operational Guidelines

**Division of Developmental Disabilities (DDD) Operational Guidelines**

The DDD Operational Guidelines represent the Division's commitment to provide a statewide system of services and supports that is efficient and effective. By establishing and documenting reasonable practices and procedures, ADMH-DDD is ensuring all stakeholders (DDD Staff and provider network) have details needed to perform their role in service delivery consistently, effectively, and efficiently. The Operational Guidelines Manual is also an effort to ensure practices and procedures are performed consistently across all regions. It is expected as our service delivery system evolves, these guidelines will also continue to evolve. All Stakeholders are encouraged to review and provide comment on proposed operational guidelines when 'presented' for review and also encouraged to propose topics where needed procedures may be of benefit.

**Development of Operational Guidelines:**

DDD Operational Guidelines are developed to document operational procedures for HCBS waiver administration, oversight, and provider guidance. They also provide further interpretation and support the operationalization of the Administrative Code.

The content identified for DDD Operational Guidelines are assigned by the DDD Associate Commissioner to the DDD Executive staff responsible for the service area to draft proposed operational procedures.

The Operational Guidelines (OGs) presented in this manual include the following information:

a. OG Number and Title
b. Responsible Office
c. References (ADMH policy or administrative code or other state/federal regulations)
d. Effective Date
e. Revised Date
f. Statement
g. Purpose/Intent
h. What waiver the OG applies to
i. Definitions *(if applicable)*
j. Procedures

Associate Commissioner, ADMH-DDD

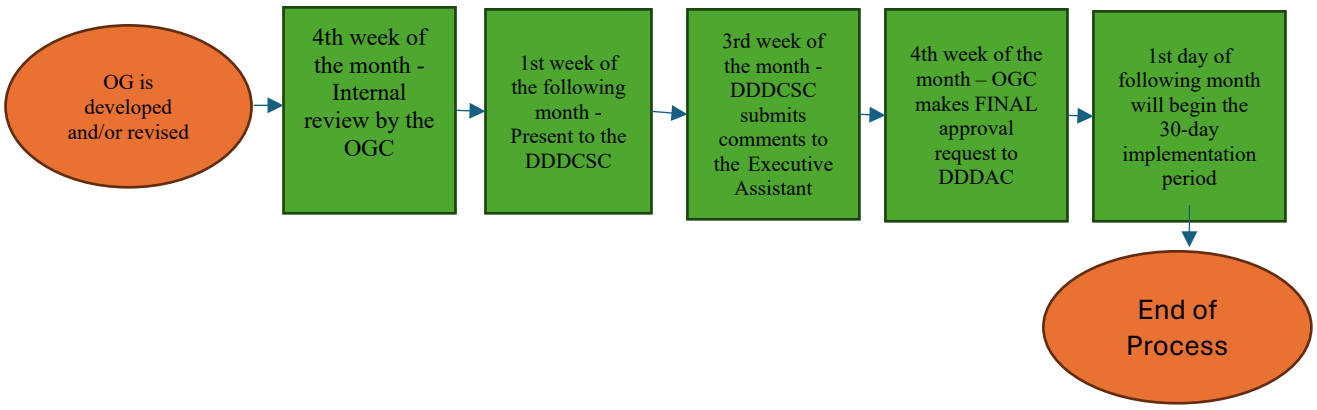
**Review steps and timeline:**

**The Associate Commissioner has the discretion to expedite the review process and/or implementation date, if warranted.*

1. The DDD Associate Commissioner and the Executive Committee (EC), will review Administrative Code 580-5-30 annually to determine if modifications are warranted.
2. The DDD Associate Commissioner and the EC will review ADMH-DDD Policies as they are presented for review by the Office of Administration to determine if modifications are warranted.
3. The Operational Guidelines Committee (OGC), which consist of the EC and oversight department specialists, will review *existing* guidelines as needed, but no less than biennially, for necessary revisions and review and approve *proposed* revisions and/or the inclusion of new guidelines monthly.
4. All revisions and/or new OGs must first undergo a legal sufficiency review in ADMH's Legal Department.
5. Once approved by ADMH Legal, the OGs will be presented to the DDD Coordinating Sub-Committee (DDDCSC). The DDDCSC is responsible for soliciting feedback from their associated members and/or other stakeholders.
6. The DDDCSC will submit stakeholder comments to the DDD Executive Assistant within 14 days of presentation.
7. The DDD Associate Commissioner along with the OGC will consider for approval all stakeholder comments for possible revisions to OGs within 14 days of receipt from the DDDCSC.
8. Within seven days the OGs shall be submitted to the Alabama Medicaid Agency (AMA) for review and comments. AMA shall have 10 days to submit their recommendations to the OGC.
9. Upon receipt or within seven days of the comments from AMA, the OGC shall make final approval recommendation to the DDD Associate Commissioner.
10. Final, approved OGs will be emailed to the appropriate oversite department for distribution.

All approved OGs will have an effective implementation 30 days from final approval. The Operational Guidelines Manual will be published once a quarter and placed on the ADMH website https://mh.alabama.gov/provider-operational-guidelines-manual/ as 'published'.

**Process Flowchart**



# Process for Revising the Administrative Code

The Administrative Code references and describes the authority and structure for the provision of services as mandated in the Alabama Department of Mental Health (ADMH) enabling statute (Act 881). The Code includes professional standards to be employed by both the Division of Developmental Disabilities (DDD)/ADMH employees and contract organizations in providing services to DDD's target population. Refer to Administrative Code 580-5-30-.03.

**Review Guidelines:**

1. The DDD Associate Commissioner and Executive Committee (EC) will review potential Administrative Code changes. The review should be completed no less than annually.
2. If there are revisions resulting from the review, the revisions are submitted to the DDD Coordinating Sub-Committee (DDDCSC) voting members for review and recommendations. The DDDCSC membership is a representation of the DDD Stakeholder network and should present comments on behalf of the associated members which include providers, families/individuals, and other advocates.
3. DDD will review the DDDCSC recommendations and integrate changes where there is agreement.
4. DDD will present for DDDCSC vote a final draft of the proposed Administrative Code.
5. Proposed changes voted out of the DDDCSC are placed on the Management Steering Committee (MSC) agenda and emailed out in advance of the MSC meeting.
6. The DDD MSC representative will present the Administrative Code changes to the MSC members for vote of approval. Proposed changes are then, voted out of the MSC.
7. Proposed Administrative Code changes are submitted to the Office of Certification who will then prepare the proposed rule change(s) to be submitted to the ADMH Legal Office and Commissioner for approval.
8. Once approved by the ADMH Commissioner, the revisions are submitted to the Legislative Services Agency (LSA). They will then be certified by the LSA and posted for public comment. Once the public comment period ends, if there are public comments, then ADMH responds to them; and if there are no comments, the rule changes are certified/codified.

   **Note:** The Legislature can also call a meeting of the Legislative Council, should there be issues with a proposed rule change.

# Home and Community-Based Settings Rule

**42 CFR §441.301(c)(4)(5)**

All settings receiving funding for HCBS Waiver services must be in full compliance with the following federally mandated Home and Community Based Settings rule. These rules apply to all direct services providers and support coordination agencies. The rule is integrated into all certification, monitoring, and Person-Centered Assessment and Planning. To arrange for training related to the HCBS Settings Rule, available to all providers, please contact the ADMH Quality Enhancement Staff in your Regional Office.

***(4)*** *Home and Community-Based Settings.* Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individualas indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access asindividuals not receiving Medicaid HCBS.

(ii) The setting is selected by the individual from among setting options including non-disability specific settingsand an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices,including but not limited to, daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the qualities at §441.301(c)(4)(i) through (v),the following additional conditions must be met:

(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that alease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided underthe jurisdiction's landlord tenant law.

(B) Each individual has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the individual, with only appropriate staff having

keys to doors.

(2) Individuals sharing units have a choice of roommates in that setting.

(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or otheragreement.

(C) Individuals have the freedom and support to control their own schedules and activities and have access to foodat any time.

(D) Individuals are able to have visitors of their choosing at any time.

(E) The setting is physically accessible to the individual.

(F) Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered serviceplan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can beterminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

**(5)** *Settings that are not Home and Community-Based.* Home and community-based settings do not include the following:

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;
(iv) A hospital; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting thatis located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

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# SECTION A – ID/LAH WAIVER

# CHAPTER 1
# ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

## A.1.1 INTAKE INFORMATION/REFERRAL

**Responsible Office:** Offices of 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; DDD Procedure 500.A.1.1

**Effective:** December 1, 2021

**Revised:** December 27, 2024

**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 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 requests must come to the CC. Regardless of the location of the caller, the county in which the legal guardian or the person resides will dictate the regional office and support coordination agency (SCA) to which the referral will be sent.

**HCBS Waivers:** ID, LAH, CWP

**Key Terms:**

Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DD)
Intellectual Disabilities (ID)
Intellectual Quotient (IQ)
Call Center (CC)
Home and Community Based Services (HCBS)
Agency (SCA)
Support Coordinator (SC):
Division of Developmental Disabilities Information Management System (DDD IMS)

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

1. Contact the Division of Developmental Disabilities Call Center (CC) at 1-800-361-4491.
2. Please note only CWP Waiver services are available in the following 11 counties: Madison, Morgan, Limestone, Tuscaloosa, Jefferson, Elmore, Montgomery, Baldwin, Mobile, Houston, Walker. ID and LAH waiver participants in those counties will continue to receive services as usual through those waivers.

3. The designated support coordination agency for each county/area serves as the point of entry for waiver applications. The designated support coordination agency (SCA) collects necessary documentation and files the application with the Regional Community Services offices.
4. It is the responsibility of the SCA to make a change in DDD IMS reflective of the assigned support coordinator from the CC.
5. Once the application is received by the SCA from the ADMH-DD CC, the intake person should contact the individual or their representative immediately; but no later than 5 business days.
6. 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.
7. Once contact with the individual seeking services has been established, the SCA will submit the completed information packet for review to the Regional Community Services 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 decision of eligibility within 30 days of the receipt of the completed application.

***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.

**Please click the link below to access form:**

**INITIAL CONTACT INFORMATION FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Initial-Contact-Information-Form.pdf

## A.1.2 WAITING LIST

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

**Responsible Office:** Offices of Community Programs, Offices of Support Coordination
**Reference:** Chapter 580-5-30-.13 Eligibility and Level of Care Determinations for Medicaid HCBS Programs, Alabama Department of Mental Health Division of Developmental Disabilities Administrative Code. Application for 1915(c) HCBS ID Waiver: AL.0001.R09.06 - Jul 01, 2024 (as of Jul 01, 2024). Application for 1915(c) HCBS Living at Home Waiver: AL.0391.R04.06 - Jul 01, 2024 (as of Jul 01, 2024), O.G. A.2.1 Appeals Process
**Revised:** January 3, 2025

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

**Purpose/Intent:** The process for determining eligibility for HCBS services and being placed on the Waiting List involves specific, crucial steps governed by detailed standards and practices of communication between the Regional Community Services (RCS) Waiting List Coordinator and the referring 310 agencies.

**HCBS Waivers:** ID, LAH

**Key Terms:**

Alabama Department of Intellectual Disabilities Information Management System (DDD IMS)
Inventory for Client and Agency Planning (ICAP)
Regional Community Services (RCS)

**Procedures:**

1. The person seeking Waiver services (or their caregiver) contacts the Call Center to initiate application.
2. The Call Center:
   a. Takes information from the caller and completes the Initial Contact Form;
   b. Opens a record for the person in the DDD IMS and enters data from the Initial Contact Form and notifies the RCS Waiting List Coordinator Community Service Director, and the 310 Board Agency of the new application via the DDD IMS; If the referral is deemed an emergency the Statewide Placement Coordinator is also notified.
   c. Determines the county of residence of the caller and notifies them of the specific Waiver programs offered in that county,
      - The ID and LAH 1915c Waivers are available in counties not covered by the Community Waiver Program.
      - In counties covered by the Community Waiver Program, the Community Waiver 1915c and the Community Waiver 1115 HCBS Programs (Group 5) are available.
   d. Informs the caller of eligibility information required to be approved for the Waiver programs available in their county of residence.
   e. Sends, via email or standard mail as the caller prefers, a letter verifying the date of the contact and outlining the eligibility determination process. Accompanying this letter is a brochure detailing the eligibility criterion for the Waiver programs in their county and examples of documentation required to satisfy them.
3. The 310 Board:
   a. Gathers information from the applicant and/or caregivers in order to accurately complete the Criticality Assessment (reference ADMH-DDD OG 1.4) and the ICAP (reference ADMH-DDD OG 1.3);
   b. Assists the applicant and/or caregivers with gathering documents needed to substantiate eligibility as described in 4.a-c;
   c. Uploads the eligibility documentation to the DDD IMS and tags the RCS Waiting List Coordinator to notify them of its availability.
4. The RCS Waiting List Coordinator reviews eligibility documentation in the application packet provided via DDD IMS by the designated 310 agency, which must include:
   a. Qualifying psychological evaluation(s) administered/interpreted by a qualified professional.
   b. Qualifying evaluations that document evidence of an intellectual disability administered before the age of twenty-two (22), as well as one conducted above age 22 for adult applicants. Applicants under age 22 will require an evaluation conducted within the past 3 years.
   c. An ICAP Compuscore report completed within ninety (90) days of the date of a complete application packet.
   d. An accurately completed Criticality Assessment

5. In order for the applicant to be deemed eligible for placement on the Waiting List, the submitted eligibility documentation must demonstrate the following for 1915c services:
    a. The applicant evidences significant problems in at least three adaptive functioning areas (Self-Care, Receptive & Expressive Language, Mobility, Self-Direction, Capacity for Independent Living, and Learning) as demonstrated through:
        - Administration of an ICAP (Inventory for Client and Agency Planning, Riverside Press) to include an ICAP Compuscore report, with corresponding information entered into the ADIDIS Eligibility Assessment, which uses an algorithm to populate the adaptive functioning problem categories.
        - The Diagnosis Record in ADIDIS (for Learning area)
        - The limitations in adaptive functioning are determined from the ICAP completed by a Support Coordinator. If necessary to support a conclusive determination, an Adaptive Behavior Scale (ABS) will be required, but only when maladaptive behavior appears to be the only factor causing the ICAP to qualify an otherwise borderline individual.
    b. The applicant achieved a full-scale IQ score of 72 or below, evidencing the presence of an intellectual disability, documented before the age of twenty- two (22).
        - If more than one IQ evaluation exists and was done prior to age twenty-two, the most recent evaluation administered will be the score considered valid unless there is a significant variation in IQ score as compared to older evaluation(s), and/or one or more of the IQ scores is above the cutoff score of 72. In this situation, the evaluations will undergo additional review by the ADMH-DDD Eligibility Review Committee to determine if 5.c. may apply. The Eligibility Review Committee consists of Regional Community Services Behavioral and Psychological Evaluators from at least three Regional Offices, who will provide a written response to the Community Services Waiting List Coordinator of their recommendations of eligibility within forty-five (45) days of receipt of request for review.
        - For all applicants, additional information may be requested and reviewed in order to confirm eligibility, in the case that submitted information is not complete or sufficient. This could include updated IQ evaluations, medical records, school documentation, etc. In the case that additional information is needed, the applicant will be notified as well as given time to gather and submit.
    c. The primary cause(s) of impaired functioning and/or the full-scale IQ of 72 or below is not the result of mental illness, a developmental disability, traumatic brain injury acquired after age twenty-two (22), or external factors such as medication, substance use effects, significant distraction, or stress.
    d. In the instance that an applicant has been evaluated by a qualified professional and a Full-Scale IQ score is determined unable to be rendered due the applicant's significant cognitive deficit/ un-testability, it is requested that the qualified professional provide an "assumed score" in writing accompanied by evidenced based justification for the score assignment. When unable to receive the "assumed score" from the qualified professional, the ADMH-DDD Eligibility Review Committee will review and render a determination.
    e. Although persons as young as three (3) years of age can be admitted to the waiver, available state plan and EPSDT services must be utilized for all participants who are under twenty-one (21) years of age.

6. **Approved Supporting Documentation** - additional documentation may be submitted for eligibility determination review:
    a. Results of all relevant educational, medical, social, or other assessments and records;
    b. Reports concerning the cause of the suspected intellectual disability;
    c. Types of services the individual has received or is receiving, whether through the school system, vocational rehabilitation, or other service systems;
    d. Records from the Social Security Administration specific to disability benefits; and
    e. Previous and current psychological, medical, and psychiatric treatments and diagnoses.

7. **Specific to the Community Waiver Program:** In the event, the applicant meets the eligibility criteria outlined in items 5.b-c., above, but does not meet the adaptive functioning criteria stipulated in item 5.a., the Waiting List Coordinator will review the applicant's ICAP Compuscore report. The applicant will be determined eligible for placement on the Community Waiver Program Waiting List for Enrollment Group 5 services if they scored below 480 in at least one of the following ICAP domains: Social & Communication, Personal Living, Community Living, or Broad Independence.
8. In the event the application packet does not include all of the documentation listed in 4.a-c above or does not unequivocally demonstrate that the person meets the eligibility criteria listed above for placement on the Waiting List, the application packet will be considered incomplete, and the Waiting List Coordinator will communicate via DDD IMS to the Support Coordination agency details on what additional information is needed to complete the packet and make a determination on eligibility.
9. In the event the needed information is not submitted within ninety90 calendar days of the Waiting List Coordinator's DDD IMS initial notification of application, 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.
10. In the event the needed information is submitted within ninety (90) calendar days, but the cumulative information does not unequivocally demonstrate that the person meets the eligibility criteria listed above, the applicant is deemed ineligible for placement on the Waiting List. The Waiting List Coordinator will send to the applicant a Wait List Denial Notification (found in the Enrollments record in the DDD IMS). A copy of this notification will be recorded in the DDD IMS.
11. For applicants with a complete application packet who've been deemed eligible for the Waiting List, within ninety days of eligibility determination, the Wait List Coordinator reviews the criticality assessment, completed by the 310 agency, to ensure:
    a. All fields are completed fully and accurately.
    b. Confirm DDD IMS eligibility conclusion through accessing the Alabama Waiting List Application Report.
12. Once eligibility has been positively determined, and the criticality assessment is reviewed and determined to be fully and accurately completed, the Waiver Coordinator will designate the person's Waiting List record in the DDD IMS as Approved, thus placing them on the Waiting List.
13. Upon approval for placement on a 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.
14. If an applicant is determined ineligible for Wait List for HCBS Waiver Services, a Wait List Denial Notification is sent, also known as a Notice of Adverse Action (NOA). The determining office will send a NOA along with the Appeal Request Form (ARF) to the applicant.

15. If the applicant feels the decision was made in error, they may appeal the decision by submitting the ARF or a written request (i.e. handwritten or typed statement, letter and/or email) requesting an appeal for an Informal Conference via email to ddoaca.dmh@mh.alabama.gov or by mail to:

    Alabama Department of Mental Health
    Office of Waiver Appeals
    P.O. Box 301410
    Montgomery, AL 36130-1410

16. More information on the appeals process can be found in Operational Guideline (O.G) Chapter Individual Rights- A.2 Appeals Process

## A.1.2.b Waiting List – Entry to Services *(Removed)*

## A.1.2.c Waiting List – Entry to Services

**Responsible Office:** Offices of Community Programs
**Reference:** 1915c Home and Community Based Intellectual Disabilities Waivers; Wait List Selection Process, A.1.2.d; Administrative Code 580-5-30-.13; DD Procedure 500.A.1.2.c
**Effective:** Historical Practice
**Revised:** August 7, 2023

**Statement:** Individuals 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.
HCBS Waivers: ID, LAH

**Key Terms:**
Division of Developmental Disabilities (DDD)
RCS (Regional Community Services)
Interchange (Medicaid Management Information System (MMIS)
ICAP (Inventory for Client and Agency Planning)
Request for Proposal (RFP)
ID (Intellectual Disabilities)
LAH (Living at Home)
Waiting List (WL).
Regional Office Community Service Director (RO CSD):
Information Management System (IMS)
Person-Centered Plan (PCP)

**Procedures:**
1. DDD Central Office notifies RCS of the applicants on the Waiting List identified for entry to Waiver services.

a. The Support Coordination agency responds to the request within five (5) business days with an explanation and timeline of actions to be taken and targeted date of completion via the web-based application, for the WL Coordinator.
b. The WL Coordinator reviews the record within three (3) business days of the response from the Support Coordination agency and at minimum every 10 business days until resolution.
c. In the event the needed additional information is not acknowledged and /or provided by the Support Coordination agency within 60 days of the initial request, the WL Coordinator will notify the Regional Office Community Services Director (RO CSD).
d. The RO CSD will request a plan of action from the Support Coordination Agency Director. The Director of Support Coordination Services and the Director of DD Community Programs will be copied on the request.

2. The Support Coordinator:
   a. Contacts the approved applicant or the caregiver, identifies needed Waiver services, and prepares the RFP.
      - In the event the Support Coordinator exhausts all available contact options and is unable to contact the approved applicant or the caregiver(s) within 10 working days of the first attempt at contact, the Support Coordinator will send a certified letter requesting immediate response to the most recent residential address on record
      - If there is no response to the certified letter within ten (10) working days from the date sent, the applicant's Waiting List Record will be denoted as "Services Not Needed/Wanted" in each service category (e.g., Residential, Day and Supports).
      - Notify the Waiting List Coordinator via the web-based application and the applicant will remain on the Waiting List with the individual record closed to Support Coordination in the web-based application.

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.

### A.1.2.d Wait List Selection Process *(Removed)*

### A.1.2.e Interregional Medicaid Waiver Transfers

**Responsible Office:** Offices of Regional Community Programs
**Reference:** A.1.2.e Interregional Medicaid Waiver Transfers
**Effective Date:** Historical Practice
**Revised:** December 31, 2024

**Statement:** Individuals receiving Medicaid Waiver services relocate their homes in new areas of the state, requiring transfer of responsibility to new RCS and Support Coordination offices and of services to new providers.

**Purpose/Intent:** When individuals receiving Medicaid Waiver services relocate to a new physical address lying in a different Region, effective communication of services, needs, and plans must occur between the RCS staff and Support Coordination staff in both sending and receiving Regions.

**HCBS Waivers**: ID, LAH

## Key Terms:

Alabama Department of Mental Health (ADMH)
Division of Developmental Disabilities (DDD):
Regional Community Services (RCS):
Person-Centered Plan (PCP):
Community Services Director (CSD):

**Procedures:**

1. In the event that a person receiving Medicaid Waiver services notifies the Support Coordinator that they intend to relocate to another area of Alabama lying in a different Region, as defined by ADMH DDD, the Support Coordinator will initiate the Request for Interregional Medicaid Waiver Transfer Form.
2. The Request for Interregional Medicaid Waiver Transfer Form will be signed by acting agencies and then forwarded, via the web-based application, to the next at each corresponding step in the process, outlined as follows.
3. The sending support coordination agency informs the sending Waiver Coordinator of:
   a. The person's/family's request for transfer to another Region (via written verification)
   b. Region to which the transfer will occur
   c. Availability of any matching funds
   d. Services the person is currently receiving and will need upon transfer
   e. Any other supports needed/requested.
4. The sending Waiver Coordinator notifies the receiving Waiver Coordinator of the request for transfer/services.
5. The receiving Waiver Coordinator determines if the needed/requested services are available in the receiving Region and informs the sending Waiver Coordinator of the results of that determination.
6. The sending Waiver Coordinator notifies the sending support coordination agency whether to proceed with the transfer or, if the needed/requested services are unavailable in the receiving Region, to meet with the person/family for additional planning.
7. If the transfer proceeds:
   a. The sending support coordination agency
      - Notifies, in writing, all current providers listed on the Plan of Care and documents the date of notification on the Interregional Medicaid Waiver Transfer Form
      - Conducts a discharge meeting.
      - Provides a Request for Proposal (RFP) to the receiving Placement Coordinator, to be distributed to Support Coordination Agencies in the receiving Region.
   b. The receiving Waiver Coordinator notifies the receiving support coordination agency to:
      - Coordinate with the sending support coordination agency to exchange all necessary documentation (e.g., releases of information, assessments, Plans of Care, etc.).
      - Establish timeframes for choice visits and a projected date of transfer.
      - Sign and return the Interregional Medicaid Waiver Transfer Form, including the date receiving providers were notified of the transfer.
8. The receiving Waiver Coordinator forwards a copy of the Interregional Medicaid Waiver Transfer Form to the sending Waiver Coordinator for distribution.

9. Upon receipt of all documentation, including (but not limited to) waiver documentation, support coordination documents, PCP, etc., the transfer will be initiated.

## A.1.3 INVENTORY FOR CLIENT AND AGENCY PLANNING FOR COMMUNITY SERVICES

**Responsible Office:** Offices of Regional Community Programs
**Reference:** Administrative Code 580-5-30.14 Eligibility and Level of Care Determinations for Medicaid Waiver Programs; DD Procedure 500.A.1.3 Inventory for Client and Agency Planning (ICAP) for Community Services
**Effective:** Historical Practice
**Revised:** December 14, 2024

**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.
HCBS Waivers: ID, LAH

**Key Terms:**
Inventory for Client and Agency Planning (ICAP):
Regional Community Services (RCS):
Support Coordination Agency (SCA):

**Procedures:**
1. Administration Requirements
   a. Prior to administering the ICAP, the Support Coordinator will be trained using an approved training curriculum developed by ADMH.
   b. Support Coordinators must complete the ADMH approved training annually and maintain proof of training in their employment record.
2. The ICAP is administered by the Support Coordinator as follows:
   a. Must be administered by the SCA upon referral from ADMH of an applicant for the Waiver and must be administered within 90 days of the application being submitted to the RCS office for eligibility determination.
   b. Must be administered when an individual is being enrolled onto the waiver, if the previous ICAP was administered more than one year prior. If the previous ICAP was administered within one year of waiver enrollment, then a new ICAP is not required.
   c. Must be administered annually within 90-days prior to re-determination of eligibility.
   d. Must be administered anytime information regarding the person served changes significantly.
3. Administering the ICAP:
   a. The Support Coordinator is responsible for administration and completion of the ICAP.
   b. Face-to-Face administration is required.
   c. The administering Support Coordinator will do an in-person interview with the applicant/person served.

d. In cases where the applicant/person served has limited communication, the Support Coordinator can include a caregiver (i.e. someone who has close, daily involvement) who is most familiar with the abilities of the person.
e. The ICAP is NOT to be given to a provider, staff person, OR family member to complete on their own.
f. The following sections of the ICAP must be completed:
    - Client information
    - Section A. Descriptive Information
    - Section B. Diagnostic Status
    - Section C. Functional Limitations and Needed Assistance
    - Section D. Adaptive Behavior (examples include: declining health, significant changes in behaviors, changes to living situation, etc.

4. **NOTE: Sections F, G, H, I, and J are not completed and/or are scored as none.** The Person-Centered Plan communication guide and assessment should be used to further evaluate support and service needs). The completed ICAP must include the date, signature, and title of the Support Coordinator completing the assessment.
5. The applicable scores yielded by the ICAP administration are entered into the Eligibility Assessment in the web- based application.
6. For reference, the completed ICAP protocol is scanned and uploaded to the record of the applicant/person served in the web-based application.

## A.1.4 CRITICALITY ASSESSMENT

**Responsible Office:** Offices of Regional Community Programs
**Reference:** Administrative Code 580-5-30
**Effective:** Historical Practice

**Reviewed:** December 31, 2024

**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.

**HCBS Waivers:** ID, LAH

**Key Terms:**
Alabama Department of Intellectual Disabilities Information Management System (DDD IMS)

**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.

## A.1.5 REQUEST FOR PSYCHOLOGICAL TESTING

**Responsible Office:** Offices of Regional Community Services
**Reference:** Administrative Code 580-5-30-.14 Eligibility and Level of Care Determinations for Medicaid Waiver Programs; DD Procedure 500.A.1.5 Request for Psychological Testing
**Effective:** Historical Practice

**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 individuals with Intellectual Disabilities (ID Waiver) and for the Alabama Living at Home Waiver (LAH Waiver)

**Purpose/Intent:** Assist individuals 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.

**HCBS Waivers:** ID, LAH

**Key Terms:**
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.

## A.1.5.a Approved Tests and Assessments for Wait List Eligibility Determination

**Responsible Office:** Offices of Community Programs
**Reference:** Administrative Code 580-5-30-.14 Eligibility and Level of Care Determinations for Medicaid Waiver Programs; DD Procedure 500.A.1.5.a Approved Tests and Assessments for Wait List Eligibility Determination
**Effective:** Historical Practice
**Revised:** Dec 16, 2024

**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 individuals with Intellectual Disabilities (ID Waiver) and for the Alabama Living at Home Waiver (LAH Waiver)

**Purpose/Intent:** Assist individuals 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.

**HCBS Waivers:** ID, LAH

**Key Terms:**
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 assessments/tests will be accepted by the AL Department of Mental Health- Division of Developmental Disabilities to determine eligibility for enrollment onto the AL- Statewide Waiting List for HCBS Medicaid ID Waiver Services. These measures satisfy the professional standards for validity and reliability required for their use in the analysis of general intellectual functioning in persons being evaluated for ID. The same is true for standardized versions of these measures available for use with individuals whose primary language is not English. Of note, qualified professionals should avoid the administering of the same intelligence test less than two years apart:
   - **A. APPROVED TESTS FOR CHILDREN, ADOLESCENTS, AND ADULTS**
     a. Wechsler Intelligence Assessment Scales- Applicable Age Range Appropriate Versions Listed Below
        - WPPSI- Wechsler Preschool & Primary Scale of Intelligence-Ages: 2:6 – 7:7
        - WISC- Wechsler Intelligence Scale for Children- Ages: 6:0–16:11
        - WAIS- Weschler Adult Intelligence Scale- Ages: 16:0-90:11

     b. SBI- Stanford-Binet Intelligence Scales- Ages: 2:0- 85:0
   - **B. APPROVED ADDITIONAL TESTS FOR YOUNG CHILDREN** The following tests will be accepted as they are more widely used specific to infants and very young children. They will be weighted applicable to age of applicant and availability of other supporting documentation that supports a diagnosis of Intellectual Disability, to include an estimated or equivalently assigned FSIQ score from the qualified professional in cases where the below tests are not designed to produce an FSIQ.
     a. BSID- Bayley Scales of Infant and Toddler Development- Ages: 1 month- 42 months
     b. BDI- Battelle Developmental Inventory - Ages: Birth- 7:11
     c. DAYC- Developmental Assessment of Young Children- Ages Birth-5: 11
     d. K-ABC- Kaufman Assessment Battery for Children- Ages: 2:5- 12:5/ K-ABC2 revised in 2004 for Ages 3:0 and 18:0
   - **C. APPROVED TESTS FOR INDIVIDUALS WITH A COMMUNICATION IMPAIRMENT** The rationale for selecting a nonverbal measure should be clearly explained by the qualified professional in the assessment report.
     a. CTONI- Comprehensive Test of Nonverbal Intelligence - Ages: 6:0 through 89:11
     b. UNIT- Universal Nonverbal Intelligence Test - Ages: 5:0 to 21:11
     c. WNS- Wechsler Nonverbal Scale - Ages: 4:0-21:11
   - **D. The below additionally listed tests are accepted for review as part of eligibility determination**. They must be accompanied by additional significant sources of supporting documentation (See described below). In isolation, these assessments will not be accepted as sufficient for eligibility determination:
     a. RIAS- Reynolds Intellectual Assessment Scale - Ages: 3:0-94:0
     b. Leiter International Performance Scale-3rd Edition - Ages: 3:0-75:0

c. OTHER TESTS NOT LISTED WILL BE ACCEPTED FOR REVIEW WITH THE SAME STIPULATIONS LISTED ABOVE.

**E. APPROVED SUPPORTING DOCUMENTATION/CORROLARY EVIDENCE**

a. Results of all relevant educational, medical, social, or other assessments and records;
b. Reports concerning the cause of the suspected intellectual disability;
c. Types of services the individual has received or is receiving, whether through the school system, vocational rehabilitation, or other service systems;
d. Records from the Social Security Administration specific to disability benefits; and
e. Previous and current psychological, medical, and psychiatric treatments and diagnoses.

**2. ESTABLISHING ORIGIN OF INTELLECTUAL DISABILITY DURING THE DEVELOPMENTAL PERIOD**

a. Evidence supporting origination of ID during the individual's developmental period, meaning before the 22nd birthday includes review of the following (as available):
b. reports concerning the cause of the suspected intellectual disability;
c. results of all relevant educational, medical, social, or other assessments and records; types of services the individual has received or is receiving, whether through the school system, vocational rehabilitation, or other service systems;
d. records from the Social Security Administration specific to disability benefits; and
e. previous and current psychological, medical, and psychiatric treatments and diagnoses.

**3. ADMH-DDD-SPECIFIC CONSIDERATIONS FOR ELGIBILITY DETERMINATION**

A. ADMH-DDD has established a fixed IQ cut-off score of 72 to determine eligibility for HCBS Intellectual Disability Waiver programs (Application for 1915(c) HCBS ID Waiver: AL.0001.R09.06 - Jul 01, 2024 (as of Jul 01, 2024). Application for 1915(c) HCBS Living at Home Waiver: AL.0391.R04.06 - Jul 01, 2024 (as of Jul 01, 2024)). In some cases, a submitted qualified professional's assessment may result in an individual not meeting eligibility criteria to be placed on the Statewide Waiting list for HCBS ID Waiver services even though the individual has a diagnosis of ID based on DSM-5 criteria, including an IQ score higher than service eligibility criteria. It is important to note that criteria for clinical diagnosis versus **criteria for eligibility of** Medicaid HCBS service programs are different based on the foundation of the waiver and the population it is intended to target.

B. Nevertheless, eligibility determinations will adhere to the defined ADMHDDD criteria to conclude that an individual has a qualifying diagnosis of ID under the agency's rules.

**4. "AGE OF ONSET" CLARIFICATION**

A. For some applicants who will apply for services later into adulthood, for which school records no longer exist, the individual did not complete their education, or special education services were not even in existence at the time. In order to meet the age of onset criteria for Intellectual Disability, it is acceptable for the qualified professional who completes the current testing/evaluation to affirm the other required components of the definition also to include a written attestation regarding age of onset. This attestation must indicate that, based on other supporting evidence (such as that obtained from past hospitalizations), the intellectual disability has existed since the developmental period.

**5. WHEN A STANDARDIZED INTELLECTUAL ASSESSMENT CANNOT BE SUCCESSFULLY ADMINISTERED.**

A. In some cases, an individual's intellectual functioning may be severely or profoundly impaired, or an individual's limitations may be so extensive, that a full-scale IQ (FSIQ) score cannot be obtained from a standardized intelligence test. In these situations, an estimate of the individual's IQ score, or IQ score equivalent should be stated with clinical justification by the qualified professional. Additional supporting documentation must be submitted that reflects consistency with estimated or equivalently assigned score.

**6. WHEN ASSESSING CHILDREN UNDER THE AGE OF 5.**

A. The DSM-5 recommends a diagnosis of "global developmental delay" (GDD) for children under the age of five years when the clinical severity level cannot be reliably assessed during early childhood. Children to whom this diagnosis would apply are those who are "…unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized testing." The DSM-5 specifies that this category requires reassessment after a period of time.

B. Based upon clinical judgment, a qualified professional has the discretion to "override" the diagnosis of GDD in favor of a formal diagnosis of ID for children under the age of five, if current measures of intellectual and adaptive functioning fall more than two standard deviations below the mean for the child's age and, given consideration of pertinent background variables, it is the conclusion of the qualified professional that current deficiencies may represent a life-long condition. However, in recognition that IQ scores can be flexible and unreliable at such an early age, a child who is diagnosed before age five should be reassessed with a full comprehensive assessment at age five by a professional specifically trained to assess children, or earlier if the child demonstrates acquisition or loss of skills that affect general intellectual ability. It is important to note that, the reassessment may determine need for continued services or warrant a disqualification of waiver eligibility.

**7. USE OF BRIEF ASSESSMENT MEASURES**

A. Qualified professionals are discouraged from using/submitting brief tests of intelligence (i.e. Kaufman Brief Intelligence Test- KBIT, Slosson Intelligence Test, Wechsler Abbreviated Scale of Intelligence- WASI) to establish an individual's initial eligibility for HCBS waiver programs. However, in limited situations an exception may be warranted. For example:

   a. The individual presents with a well-established, documented testing history based on broad-based batteries and brief test results are consistent with testing history;

   b. The individual participated in multiple cognitive tests that yielded consistent scores, yet a more current IQ score is required and there is not present availability of a comprehensive measure that can be conducted.

B. The rationale for use of a Brief measure and justification for its use in the psychological report must be explained by the qualified professional. However, any significant change (including a decline or improvement) in functioning since the last evaluation would rule against the use of a brief test. In cases where there is not appropriate justification for the use of a brief IQ test, the evaluation may be disqualified as part of the eligibility review.

## A.1.6 WAIVER SERVICES

### A.1.6.a Wait List Services for Children *(Removed)*

### A.1.6.b Waiver to Waiver Transfers

**Responsible Office:** Offices of System Management
**Reference:** Alabama Medicaid Long Term Care Division Policy
**Effective:** Historical Practice

**Statement:** Required Elements for Waiver-to-Waiver Transfers

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

**HCBS Waivers:** ID, LAH

**Key Terms:**
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.

### A.1.6.c Termination of Waiver

**Responsible Office:** Offices of System Management
**Reference:** Medicaid Administrative Code
**Effective:** Historical Practice

**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.

**HCBS Waivers:** ID, LAH

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

- Hospitalization-termination one full calendar month of hospitalization.
- Nursing Home placement-termination after 48 hours of placement
- Moved out of state-termination after 60 days out of state
- Death-immediately following notification.
- No longer meets eligibility requirements-immediate
- No longer request waiver services-immediate
- Refusal to adhere to program requirements- 30 days following written notification
- Transfers to another waiver program-on the last working day of a month.
- Unable to locate waiver participant-30 days after written notification to last known address remains without response.
- 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.**

### A.1.6.d Waiver Admission & Discharge (*Removed)*

### A.1.6.e Request for Proposal Seeking Services for Individuals

**Responsible Office:** Offices of Regional Community Programs
**Reference:** 1915c Home and Community Based Intellectual Disabilities Waiver
**Effective:** Historical Practice
**Revised:** April 7, 2023
**Reviewed:** December 31, 2024

**Statement:** When a person is approved to receive or change Waiver services/providers, a Request for Proposal to provide services is circulated to certified providers of the needed service(s).
Purpose/Intent: The Request for Proposal is prepared by the Support Coordinator with the goal of communicating essential information about the person served, such that potential providers may make an informed decision about their potential ability to successfully serve that person.

**HCBS Waivers:** ID, LAH

**Key Terms:**

RCS (Regional Community Services):
Request for Proposal (RFP):
BCBA (Board-Certified Behavior Analyst):
BSP (Behavior Support Plan):

**Procedures:**

1. The RFP is prepared by the Support Coordinator within five (5) business days when:
   a. An applicant for Waiver services initially enters service.
   b. A person served on the Waiver adds a new service.
   c. A person served on the Waiver elects to change providers.
2. The RFP must identify current support needs to include the following:
   a. Social (family, caregiver, mentor, support coordinator involvement)
   b. Environmental (home layout, housemate structure, routine accommodations, etc.)
   c. Community Supports (mental health resources such as psychiatrist and/or therapist, extracurricular opportunities, etc.)
3. The RFP must also include the following essential information:
   a. Basic demographics (i.e., age, gender, city/county of residence, height/weight)
   b. Current and historical behavioral presentation
   c. BCBA/BSP involvement
   d. Psychiatric diagnoses
   e. Medical diagnoses
   f. Medical history
   g. Current medications
   h. Medication self-administration ability
   i. Communication skills
   j. Mobility skills
   k. Self-care skills
   l. Adaptive equipment needs
   m. Most recent intellectual and adaptive testing data
   n. Current Waiver services received
4. Immediately upon completion of the RFP, the Service Coordinator circulates it, via email, to all providers local to the person and who offer the needed service(s). Interested providers are afforded seven (7) business days to respond to the circulated RFP. The RFP is uploaded into the Information and Management System making the Regional Office Waiting List Coordinator a read recipient.
5. If the RFP is circulated and receives no responses from providers, it will be circulated a second time, within five (5) business days, again with a response time frame of seven (7) business days.
6. If the RFP is circulated a second time and receives no responses from providers, the Service Coordinator submits the RFP to the RCS Waiting List Coordinator and, within three (3) business days, the Waiting List Coordinator reviews it for completeness and accuracy.
7. The Waiting List Coordinator will consult with the Community Services Director and the Support Coordinator to identify prospective providers with program vacancies and compatible services offered. The Waiting List Coordinator will directly contact these prospective providers to propose the possibility of serving the person in need of services, within five (5) business days.

8. In the event that no local provider responds to the RFP(s), the applicant/person served may elect to have the RFP circulated in other fiscal Regions, for consideration by providers in those areas. If this is the decision of the person, the Waiting List Coordinator in the Region of the person's residence will share the RFP with the Waiting List Coordinator(s) in the Region(s) encompassing any other areas the person chooses to seek services, and the RFP process noted above will then be followed there.

**Please click the link below to access form:**

**ADMH REQUEST FOR PLACEMENT & INSTRUCTIONS FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/ADMH-Request-for-Placement-and-Instructions.pdf

# CHAPTER 2
# INDIVIDUAL RIGHTS

## A.2.1 APPEALS PROCESS

**Responsible Office:** Offices of Community Programs, Offices of Support Coordination, and Offices of Waiver Appeals
**Reference:** 42-CFR 431.210 (Subpart E); ID and LAH Waivers and Community Waiver Program (CWP); Rule No. 560-X-35-.17; Rule No. 560-X-43-.16; Rule No. 560-X-52.15
**Effective:** Historical Practice
**Revised:** December 11, 2023

**Purpose/Intent:** Appeals function both as a process of clarifying and interpreting the criteria and standards by which the original decision was rendered as well as a process for error correction, when applicable regarding decisions made specific to the HCBS Waiver Programs for individual with Intellectual Disabilities.
The procedures below clearly outline the steps in the appeals process which include: notification of adverse action, requesting an appeal for an Informal Conference or Fair Hearing, and decision making and resolution for individuals: (a) who are denied service(s), choice of provider(s), or whose services are(b) suspended, reduced, terminated or delayed.

**HCBS Waivers:** ID, LAH, CWP

**Key Terms:**
Adverse Action
Notice of Action (NOA)
Appeal
Informal Conference
Fair Hearing
CWP (Community Waiver Program)
SRC (Special Review Committee)
AMA (Alabama Medicaid Agency)
CSD (Community Services Director)
OWA (Office of Waiver Appeals)
ARF (Appeal Request Form)
AMA Waiver Program Manager)

**Procedures:**
The appeals process begins with a NOA (Notification of Action to an applicant). This notice will specify the reason for the adverse action and provide instruction for requesting an appeal of the decision if desired.

1. When an adverse action is determined, the determining office will send a NOA along with the Appeal Request Form (ARF) to the applicant.

2. If the applicant feels the decision was made in error, they may appeal the decision by submitting the ARF or a written request (i.e. handwritten or typed statement, letter and/or email requesting an appeal)for an Informal Conference via email to ddoaca.dmh@mh.alabama.gov or by mail to:

Alabama Department of Mental Health
Office of Waiver Appeals
P.O. Box 301410
Montgomery, AL 36130-1410

**NOTE: If the applicant chooses to submit a written request instead of the ARF form, the following information must be included:**

a. The full name of the applicant,
b. Contact information of applicant (mailing address and/or email),
c. The full name of requestor of the appeal (if applicable),
d. Contact information of requester, if different from the applicant (mailing address and/or email),
e. Adverse action taken (denial, termination, suspension or reduction in services), and
f. Reason for requesting an appeal.

3. The request for appeal must be received by ADMH-DDD within 15 calendar days of the effective date printed on the NOA.
4. Upon receiving the NOA or written request of appeal, the Appeals Coordinator will:
   a. Send a letter of receipt to the requestor of the appeal, or
   b. If received after 15 calendar days, send a letter to the requestor of the appeal noting that the appeal for an Informal Conference to ADMH is unable to be reviewed due to being received beyond the defined time limit.
5. Following the timely receipt of a request of appeal for denials of waiver eligibility, a panel of ADMH-DDD clinical professionals will be selected to provide a thorough review of the documents submitted in the original application and those submitted as part of the appeal request. The requestor of appeal may be contacted for more information and further supporting documentation. A decision will be rendered to uphold or reverse the original denial after review is completed.
6. Following the timely receipt of a request of appeal for the denial, termination, reduction or suspension of waiver services, the Appeals Coordinator will:
   a. Assemble a review panel, and
   b. Provide each member of the review panel with an appeal packet.
7. The members of the review panel will individually review the appeal packet and submit to the Appeals Coordinator an Initial Review of Denial form.
8. Appeals Coordinator will compile panel member's responses on the Initial Review of Denial form and send the official form to all panel members prior to the informal conference.
9. The Informal Conference will consist of either a thorough review of documents and discussion by the panel members or a teleconference which includes the individual and requestor of the appeal if different from the individual. The applicant will be able to choose which option best suits their needs for the Informal Conference by notifying the Appeals Coordinator. The requestor of the appeal will notify the Appeals Coordinator with their decision on the type of Informal Conference via email or by mail.

***INFORMAL CONFERENCE:***

The applicant is entitled to a review which may involve a teleconference, or a thorough review of documents.

1. Review:

a. A review will be scheduled with the 1) individual and as appropriate, the individual's representative (ex., family, guardian, authorized representative), if they are the requestor of the appeal. The individual for whom an Informal Conference was requested can attend, if possible (for the teleconference option) if he/she is capable. In the event that the individual nor their representative is not present for their initially scheduled Informal Conference teleconference, they may request that it be rescheduled for a later date/time. If the individual and/or their representative does not attend the rescheduled Informal Conference teleconference, an appeal decision will be determined based on the review of documents and discussion completed by the panel members 2) selected panel members, which will consist of a combination of staff from another Regional office, staff within the DD Division employed at the Central Office who did not have a role in the original denial, and an AMA Waiver Program Manager, 3) Staff responsible for denying the RFA (Regional CSD, Wait List Coordinator, or CWP Director or a designee), 4) Individual's Support coordinator.

b. The teleconference option will provide the individual and their representative the opportunity to offer additional supporting information. The panel will also utilize the time to ask any specific questions to the staff, individual and/or their representative.

2. Decision Making and Notification:

a. The ADMH-DDD Appeals Coordinator and selected panel members will meet after the teleconference (if this option is selected) or at a scheduled date and time to discuss and reach a decision to either reverse, uphold, or pend the decision. If the appeal is pending the review of additional information, the below steps should be followed:

- The individual/family/representative will be notified via email and/or mail of the panel members request for additional information, along with the individual's support coordinator.
- The individual/family/representative will have no more than 15 calendar days to provide the additional informational that was requested to the Office of Waiver Appeals. If the requestor of the appeal is unable to provide the additional information, they must notify the Appeals Coordinator who will relay that information to the panel members.
- Once the additional information has been received, the Appeal Coordinator will distribute the additional information to the appeals review panel members to review individually.
- After the additional information has been distributed, the Appeals Coordinator will set a time and date for the appeals review panel to meet again within 7 calendar days to discuss and decide on whether to uphold or reverse the original decision.

b. Once a decision has been reached, the panel will complete the Review of Denial Form indicating reasons for their decision.

c. The panel will select a panel participant to submit in writing the final informal conference decision made by the panel and all supporting information to the Appeals Coordinator.

d. The Appeals Coordinator will submit a letter to the Associate Commissioner for review and approval that includes the following:

- Description of initial request that warranted a denial
- Action(s) taken to review the appeal
- Final informal conference decision (denial upheld or reversed) and supporting reason (resource or other information to support decision)
- Effective date of decision (if appropriate)

- Process for the option to request an AMA Fair Hearing should the denial be upheld by the Associate commissioner and the individual and/or their representative remain in disagreement with the decision.

e. Upon obtaining the Associate Commissioner's review and decision, the Appeals Coordinator will notify the individual and if applicable, the individual's representative (person requesting the appeal) in writing within 15 calendar days.
   - If the Associate Commissioner upholds the decision of denial, the Appeals Coordinator will include in the notification to the individual the process for requesting a Fair Hearing with AMA.

f. The Appeals Coordinator will upload the letter into ADIDIS, adding as a note to the recipient's record, and tag the individual's Support Coordinator, Director of Community Programs, Regional CSD, the ID/LAH/CWP Waiver Director, the Regional Office Fiscal Manager and others as appropriate. The Appeals Coordinator will send a copy of the letter to AMA program manager via email.

***FAIR HEARING:***

If the individual/guardian disagrees with the ADMH Associate Commissioner's decision, he/she can submit a request for a Fair Hearing to the Alabama Medicaid Agency (Medicaid). A written hearing request must be received by Medicaid no later than 15 calendar days from the date of the ADMH Associate Commissioner's response letter.

Alabama Medicaid Agency
LTC Healthcare Reform Division
P.O. Box 5624
501 Dexter Avenue
Montgomery, AL 36103-5624

**Please click the link below to access forms:**

**NOTICE OF APPEAL ADVERSE ACTION FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Notice-of-Appeal-Adverse-Action.pdf

**DISSATISFACTION OF SERVICES GRIEVANCE FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Dissatisfaction-of-Services-Grievance-Form.pdf

### A.2.1.a Waiver/Wait List Eligibility Appeals *(Repealed)*

### A.2.1.b Appeals Process for Adverse Actions- Services *(Repealed)*

## A.2.2 DISSATISFACTION OF SERVICES/GRIEVANCE PROCESS

**Responsible Office:** Offices of Community Programs, Offices of Support Coordination, and Offices of Waiver Appeals
**Reference:** 42 CFR 441.3029d0. Intellectual Disabilities and Living at Home HCBS Waivers
**Effective:** December 16, 2024

**Revised:** January 3, 2025

**Purpose/Intent:** The Dissatisfaction of Services/ Grievance Process is a disclosure required by Alabama Medicaid Agency and is handled through the Alabama Department of Mental Health's Office of Advocacy Services to ensure a person enrolling or already receiving HCBS waiver services and their legally authorized representative are aware that they have a right to due process should they become unsatisfied with Medicaid funded services and/or service providers.

**HCBS Waivers:** ID, LAH, CWP

**Key Terms:**
HCBS
People
Support Coordinators
Regional Community Services Office Staff
Due Process Medicaid review of the case/complaint and/or a Fair Hearing
ID
LAH
Grievance

**Procedures:**

1. The Support Coordinator must review and complete the Dissatisfaction of Services/Grievance Process and Notification form with the participant at the time of new admission and annual redetermination. Prior to, and during the person-centered planning meeting, the participant is made aware that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing once they are selected from the wait list and services begin. A waiver participant should always be notified of their right to file a complaint/grievance when changing and/or adding waiver services. The waiver participant must sign and date the Notification form confirming the understanding of their rights. A copy of the signed Notification form must be filed securely and maintained in the waiver participant's file.
2. If a waiver participant becomes dissatisfied with a provider and/or the delivery of supports and services, he/she has the right to select a different provider and the Support Coordinator will assist with this process. This process may include an interdisciplinary team meeting to include a representative from the local Regional Community Services Office and/or an advocate to address any issues or concerns prior to a change in provider(s). However, if for any reason a participant believes that their rights have been violated in any way by ADMH/DDD support staff and/or a provider he/she can file a formal complaint/grievance in writing, or verbally directly to the Alabama Department Mental Health Office of Rights Protection & Advocacy. The Department maintains an independent Office of Rights Protection & Advocacy services, reporting directly to the Commissioner's office, which monitors programs, receives complaints through a toll-free advocacy access line during normal State of Alabama business hours (the number is required to be posted in every certified site and given to each waiver participant), and investigates any rights issue complaints received. A voicemail response is left on the phone line, encouraging after-hour callers to leave a message, which will be retrieved and responded to on the next regular business day. The recorded message also offers options for the caller to follow if more immediate assistance is required.

3. The types of rights issue complaints that may be reported and will be investigated fall into the following rights categories: a) Due process; b) Education; c) Complaints; d) Safe and humane environment; e) Protection from harm; f) Privacy/confidentiality; g) Personal possessions; h) Communication and social contacts; i) Religion; j) Confidentiality of records; k) Labor; l) Disclosure of services available; m) Quality treatment; n) Individualized treatment or habilitation; o) Participation in treatment or habilitation; p) Least restrictive conditions; q) Research and experimentation; r) Informed consent.
4. Complaints of abuse, neglect, exploitation, or mistreatment are immediately referred to the responsible program and an investigation is also initiated by Advocacy staff or the program within 24 hours. Any other complaint that, in the opinion of the advocate, involves threat to health or safety is treated the same way. Other complaints are opened, responsible parties notified, and investigations are initiated as soon as possible but no later than seven (7) working days of the report, with the expectation that the investigation will be completed within thirty (30) working days.
5. The Office of Rights Protection & Advocacy will complete a thorough and adequate investigation of the complaint/grievance to provide a resolution. Resolution is required of the provider agency, which must submit a written report. If resolution requires ongoing monitoring, the responsible division's staff will provide this. If resolution requires court intervention, the federal protection and advocacy agency known as the Alabama Disabilities Advocacy Program, or the Alabama State Bar Referral Service may be contacted to arrange legal representation for the waiver participant. If the waiver participant is receiving services under the waiver and his/her complaint involves waiver related issues, and he/she cannot achieve satisfaction through the required resolution, the waiver participant and/or their representative will be referred to the Medicaid Waiver Program Manager for initiation of the Medicaid Fair Hearing Process. This rarely occurs, because the authority of the DMH Office of Advocacy Services should be able to resolve most problems.
6. After a resolution is determined, the waiver participant will receive a written notification of the resolution within seven (7) business days of the completed investigation process (note: the investigation process can take up to thirty (30) working days).
7. If a participant chooses to file a grievance/complaint, a written request of a review of their case can be mailed or emailed by the waiver participant, representative, relative, advocate, attorney or other involved spokesperson of their choice to the ADMH Office of Rights Protection & Advocacy. An individual can also contact the Office of Rights Protection & Advocacy toll free number as described in (2).

Alabama Department of Mental Health
Office of Rights Protection & Advocacy
RSA Union Building
100 North Union Street
P.O. Box 301410
Montgomery, AL 36130-1410
Phone: 1-800-367-0955
Fax: 334-242-0747 Email: Alabama.DHM@mh.alabama.gov

8. All grievance/complaints must be filed, stored properly, and made available to AMA on a quarterly basis. The quarterly reports to AMA must comprehensively list the waiver participant's information inclusive of the specific waiver of enrollment, the nature of the complaint/grievance, the finding(s) of the investigation, and the resolution. There should be a clear timeline provided for each case to

ensure the process was reviewed and completed within the expected time frame. The quarterly reports must be sent to Alabama Medicaid Agency's Quality Assurance Director and ID, LAH and CWP Program Manager(s) via email no later than fifteen (15) days after the end of each quarter.

### A.2.3 INFORMAL CONFERENCE- SERVICES *(Repealed)*

### A.2.4 FORENSIC CASES *(Repealed)*

# CHAPTER 3
# INDIVIDUAL SUPPORT PLANNING AND IMPLEMENTATION

## A.3.1 PERSON CENTERED PLAN (PCP) PROCESSING THROUGH DDD INFORMATION MANAGEMENT SYSTEM (FORMERLY PLAN OF CARE)

**Responsible Office:** Offices of Community Programs
**Reference:** Administrative Code 580-5-30-.13; 1915 Home and Community Based Intellectual Disabilities Waiver
**Effective:** Historical Practice
**Revised:** January 17, 2025

**Statement:** The Person-Centered Plan outlines specific services chosen and approved by the individual and/or family and Support Coordinator (SC), to be implemented by recipient's chosen service provider.

**Purpose/Intent:** To outline specific steps required for reviewing, updating and generating the person-centered Plan (PCP) in DDD Information Management System (IMS) which enables authorization of services (i.e., volume, frequency, and start date) and provides a current record of the services authorized for a recipient.

**HCBS Waivers:** ID, LAH

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

**Procedures:**
1. The PCP 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 (RFA) policy.
2. The Support Coordinator generates the PCP via the Person-Centered Plan tab in DDD IMS and:
   a. Records the Begin date of the PCP 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 PCP.
   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 PCP is modified.
   d. Records the end date of the PCP and of individual services as one year from the Begin/Start date.
   e. Obtains the necessary signatures indicated on the PCP.
3. The Support Coordinator uploads the PCP to the Notes tab of DDD IMS and:
   a. Tags the Waiver Coordinator as a Note Recipient on the Note to which the PCP is attached.

# CHAPTER 4
# SUPPORT COORDINATION
# (CASE MANAGEMENT)

## A.4.1 FUNDING FOR SUPPORT COORDINATION AGENCIES *(REMOVED)*

### A.4.1.a Intake Billing Process for Support Coordination

**Responsible Office**: Offices of Support Coordination Services and Offices of Fiscal Management
**Reference:** Administrative Code Chapter 580-5-31 and 580-5-31-14: ADMH Medicaid Waiver Programs; Operational Guidelines A1.1, A.1.2a, A.1.2b, A.1.2c, A.1.2.d, A.1.3, A.1.4, A.1.5
**Effective:** December 14, 2024

**Purpose/Intent:** To describe the process Support Coordinators use to determine if an intake application is considered a complete application or incomplete application and when the SCA can submit billing for intake process.

**HCBS Waivers:** ID/LAH/CWP

**Key Terms:**
Inventory for Client and Agency Planning (ICAP)
Division Developmental Disabilities Information Management System (DDD IMS)
Region Office (RO)
Support Coordination Agency (SCA)

**Procedures:**

A. Categories of the Intake Application
   1. Complete Application:
      a. Once all eligibility documentation has been received and Inventory for Client and Agency Planning (ICAP) administered, the Support Coordination Agency (SCA) completes Eligibility Assessment, Criticality Summary and Diagnosis in the Division Developmental Disabilities Information Management System (DDD IMS). The Wait List application is submitted to the Region Office (RO) through DDD IMS for determination of eligibility. Eligibility documentation is reviewed by the RO Waitlist Coordinator to determine approval or denial of waiver admission to the Wait List. The SCA will submit the completed Intake Invoices via email to the designated Division Developmental Disabilities (DDD) fiscal office staff.
   2. Incomplete Application:
      a. If the SCA is unsuccessful in contacting the applicant and/or their representative within 60 calendar days of the referral, the SCA must notify the RO Wait List Coordinator. The SCA is required to document all attempts made in an effort to contact the person and/or their representative in the DDD IMS. A reasonable effort to make contact would be two (2) documented phone calls and a letter mailed to the individual. The SCA will submit the completed Intake Invoices via email to the designated DDD fiscal office staff.
      b. After the eligibility documentation has been received and the ICAP has been administered, the SCA will complete the Eligibility Assessment, Criticality Summary and Diagnosis in DDD IMS. The Wait List application is then submitted to the RO through the DDD IMS for determination of eligibility. If eligibility documentation is not sufficient to properly make a determination, the RO Wait List Coordinator will notify the SCA regarding the needed documentation necessary to make a determination. If the necessary documentation is not

received within 60 calendar days of the request being made by the RO Wait List Coordinator, the application will be deemed incomplete.

3. Voluntary Withdrawal by Family:
   a. At any time during the intake process if the applicant or their family/representative informs the SCA that they no longer want to continue with the intake process, the SCA must notify the RO Wait List Coordinator through DDD IMS of the applicant's and/or family's decision to withdraw from wait list application process.
   b. The WL Coordinator will document receipt of notification from the SCA in the DDD IMS.
   c. The applicant/family will receive a generated letter from ADMH confirming the conclusion of the application process.

B. **Intake Billing Process:**
   1. The SCA will submit billing for intake using the Intake Invoice (see attached) after A, B, or C has been completed to the DDD fiscal office staff. All attempts (successful and unsuccessful) to contact the individual must be documented in the DDD-IMS.
   2. SCA will complete the Intake Invoice form for every individual documenting the date and time the contacts were attempted and made with the individual and/or family member. SCA's will include all work within the process of the current intake to justify the payment including current Fiscal Year, Vendor Number, Contract Number, SCA name, physical address that must match the address in STAARS.
   3. The Invoice Date is the date the invoice is submitted to DDD fiscal staff.

## A.4.2 REQUEST FOR ACTION/SERVICES

**Responsible Office:** Offices of System Management
**Reference:** Administrative Code Chapter 580-5-31 and 580-5-31-14: ADMH Medicaid Waiver Programs; Operational Guidelines ADMH/DD Operational Procedures
**Purpose/Intent:** To expedite the RFA process
Disabilities Information Management System)
**Effective:** Historical Practice
**Revised:** February 25, 2025

**Key Terms:**
RFA (Request for Action)

| |
|---|
| Region 1 RFA |
| Region 2 RFA |
| Region 3 RFA |
| Region 4 RFA |
| Region 5 RFA |

Each Regional Office will meet weekly to review all requests for the perspective regions. Only requests that are submitted by 12 noon the day before the meeting are considered for review. **Please ensure all supporting documents are submitted with the RFA.**
Please contact your Regional Office directly to inquire about the day they meet. If a request requires immediate approval, please contact the Waiver Coordinator and Community Services Director directly via email, with a follow-up in the Information Data System.

Requests for Special Level Staffing (Behavioral/Medical), Positive Behavior Supports, and Comprehensive Support Services are submitted to the Regional Office Behavioral and Psychological Evaluator for review and approval. All other medical requests not related to special level staffing are submitted to the Regional Office Nurse for review and approval.

**A. <u>A RFA is required for all services:</u>**

Following a team meeting where all appropriate individuals attend, ADMH/DDD requires the support coordinator to submit the Request for Action (RFA) form to the Regional Office Waiver Coordinator through the RFA Regional account for all changes to the PCP service page (formerly plan of care). The Regional Office should make the determination within no more than seven (7) business days to expedite service delivery. If required information is not received by the Regional Office within (7) business days, the RFA will be returned to the Support Coordinator via the Information Data System and mailed to the waiver participant as incomplete. **Please note waiver services should not start until an approval is received from the Regional Office.**

**<u>The following are examples of supporting documents needed when requesting waiver services:</u>**

1. Assistive Technology
    a. Include medical documentation and prescription
    b. Quote for service
    c. Denial from other insurance (if applicable)
    d. Justification of needed service
2. Environmental Accessibility Adaptations (EAA)
    a. Include medical documentation
    b. Three (3) quotes for service
3. Specialized Staffing (SS)*
    a. Please reference Operational Guideline 7.2 for required documentation
    b. Submit to the Regional Office of Behavioral and Psychological Evaluator
4. Positive Behavior Supports (PBS)
    a. Include BSP, PMP, and data
    b. Justification to increase services must be included in team meeting minutes
    c. If needed to develop a PMP or BSP, submit data and anticipated completion date for the plan(s)

5. Changes in staffing levels for participant in Residential Services
    a. Please reference Operational Guideline 8.1
6. Specialized Medical Supplies
    a. Include Prescription
    b. Include Freedom of Choice
    c. Denial from other insurance (i.e. Medicaid State Plan)

**B. <u>Procedures for Support Coordinator when submitting a RFA:</u>**

1. Hold a team meeting of appropriate people
2. Provide signed team meeting minutes and sign-in
3. Check Medicaid State Plan Services (SPS) and other insurance to ensure an item is not covered (if applicable)
4. Obtain required supporting documentation as necessary (prescriptions, medical documentation, quote, ICAP, etc.)
5. Complete the RFA Form with a detailed description (formal or informal assessments) that supports the request
6. Add service to the PCP service page (formerly plan of care) using the following format:
    a. Provider Name
    b. Service Code
    c. Service Name
    d. Units
    e. Unit Type
    f. Cost (if applicable)
    g. Start Date and end date should be left empty or say upon approval
        - Exception - for hospital/nursing home discharges, the start date will be written as the date of discharge
    h. Obtain signatures
    i. Use “A” to add services and “T” to terminate services
7. Submit the RFA Form, service page and signature page to the designated Regional Office RFA Account electronically through Information Data System once all required documentation is received and leave in pending status.
8. When additional information is requested for any request, the Regional Office will add a note in Information Data System and tag the assigned Support Coordinator. It is imperative that Support Coordinators review their notes to avoid delays in services.
9. In emergency situations, please indicate the start date on the RFA and PCP service page (formerly plan of care).

**Please click the link below to access form:**

**<u>REQUEST FOR REGIONAL ACTION & INSTRUCTIONS FORM</u>**

https://mh.alabama.gov/wp-content/uploads/2025/05/Request-for-Regional-Action-and-Instructions.pdf

## A.4.3 REDETERMINATION

**Responsible Office:** Offices of Support Coordination and Offices of Systems Management
**Reference:** Administrative Code 580-5-30.14 (2) (d) Level of Care Determination for Alabama Medicaid Waiver Programs, 1915c Home and Community Based Intellectual Disabilities Waiver, 1115 Demonstration
**Effective:** December 31, 2024
Revised: April 23, 2025

**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:** ADMH-DDD Central Office; Regional Offices

**HCBS Waivers:** ID, LAH

**Key Terms:**
DDD IMS (Division of Developmental Disabilities Information Management System)
ICAP (Inventory for Client and Agency Planning)
LOC (Level of Care)
Interchange
LTC-2 (Long Term Care Notification)
ABS (Adaptive Behavior Scale)
IQ (Intelligence Quotient)
RO (Regional Office)

**Procedures:**
1. The Support Coordinator:
   a. Completes supporting documentation:
      - Signed Person-Centered Plan
      - Freedom of Choice
      - Person Centered Assessment and Plan
      - Physical or RN Assessment (only until physical is obtained) (~~CWP use Physical Form~~)

        ***NOTE: The attached annual physical form is recommended. If not used, Support Coordinators should encourage families to consider discussing all elements of this assessment with their physician.***

      - ICAP
      - Psychological
   b. Submission of all supporting documentation no later than the 15th day of the month prior to the expiration of the Waiver determination and uploaded to the DDD IMS Notes tab. NOTE: *Please*

*be advise failure to submit all required documentation by the deadline may result in the individual's waiver services to be discontinued*.

**Please click the link below to access form:**

**ANNUAL PHYSICAL EXAMINATION FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Physical-Examination-Form.pdf

## A.4.4 SUMMARY PROGRAM OF HABILITATION *(Repealed)*

## A.4.5 MONITORING - INDIVIDUAL EXPERIENCE ASSESSMENT SURVEY

**Responsible Office:** Offices of Support Coordination
**Reference:** 2014 HCBS Rule
**Effective:** Historical Practice
**Revised:** July 1, 2024

**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 individuals 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.

**HCBS Waivers:** ID/LAH

**Key Terms:**
People
Support Coordinators
ID Waiver
LAH Waiver

**Procedures:**
1. Support Coordinators shall assess waiver recipient moving into NEW settings within 5 days before or after day 60 of enrollment in waiver services and/or move into the new setting. See OG 5.13 New Settings HCBS Compliance for monitoring compliance.
2. For waiver recipients 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 waiver recipient and his or her family members and/or representative, as appropriate. The waiver recipient'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 waiver recipient and his or her family and/or representative.
4. Results are submitted to the provider and the Regional Office Monitor via the information management system, tagging the monitors as a note recipient, 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 PCAP and 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. See OG 5.13 New Settings HCBS Compliance for remediation process and timeframes.
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 C does not automatically indicate Not in Compliance.

**Please click the link below to access form:**

**INDIVIDUAL EXPERIENCE ASSESSMENT SURVEY FORM:**
https://mh.alabama.gov/wp-content/uploads/2025/05/Individual-Experience-Assessment-Survey.pdf

## A.4.6 RECOUPMENT POLICY *(Removed)*

## A.4.7 CONFLICT FREE SUPPORT COORDINATION/CASE MANAGEMENT SERVICES

**Responsible Office:** Offices of Support Coordination
**Reference:** CMS Regulations 42 CFR 441.301 © (1) (vi), Affordable Care Act
**Effective:** December 30, 2024

**Statement:** The Alabama Department of Mental Health Division of Developmental Disabilities (DDD) shall ensure that providers of Home and Community Based Services (HCBS) or those who have an interest in providing these services and/ or those who are employed by a provider of HCBS do not also provide support coordination services or develop person centered plans for the person receiving HCBS.

**Exception:** Exception to this policy is granted when the DDD determines that the only willing and qualified entity to provide support coordination services and/or develop person centered service plans in a geographic area (county) also provides HCBS; known as a sole provider for the purposes of this policy**.**

**Standards:**

1. When the DDD determines there is a sole provider of both support coordination and HCBS in a geographical area (county), the DDD shall seek to identify and procure a qualified support coordination provider to establish conflict free support coordination in the conflicted area.

2. If no qualified support coordination provider is identified for the service area, the DDD may seek to employ service coordinators and directly provide services for the conflicted area.

3. If it is established there are no qualified providers or the DDD is unable to employ service coordinators for the conflicted area, the DDD shall verify the sole provider status and establish robust monitoring and oversight
   procedures, including conflict of interest protections.

4. Conflict of Interest Protections shall ensure:
   a. Clinical or other non-financial eligibility determination is separate from direct services.
   b. Support coordinators and professionals who evaluate a person's needs for services are not related to the individual, their paid caregivers, or anyone financially responsible for the individual.
      Support coordinators are not financially responsible for the person receiving services and are not empowered to make health-related decisions on behalf of the person served.
   c. There are clear and accessible procedures for persons receiving services to assert grievances and/or appeals concerning eligibility determinations, choice and service quality, provisions and outcomes. Outcomes related to these procedures are adequately tracked monitored and implemented.
   d. Quality Management and Improvement strategies and measures are utilized to track and address the person's experiences and satisfaction related to support coordination. These strategies shall include meaningful engagement of stakeholders including, persons served and their family members, advocates, providers, DDD staff and coordinators.
   e. Under no circumstance should an agency providing support coordination house a support coordinator within another provider agency with the sole purpose of providing coordination services to individuals receiving services in that facility.
   f. Under no circumstances shall there be undue influence over goals, compromised individual choice of services, misaligned financial incentives or provider self-referral.

## A.4.8 SUPPORT COORDINATION GUIDELINE

**Responsible Office:** DDD HCBS Waiver Service Providers, Offices of Support Coordination, ADMH-DDD Central Office and ADMH Regional Offices

**Reference:** Alabama Administrative Code 580-1-2, 580-3-26, 580-5-30; Appendix D – ID/LAH Waivers; Support Coordination Quality Review and Certification Standards; Support Coordination Scope of Service; OG A.4.3 Redetermination, A.4.7 Conflict Free Support Coordination/Case Management Services and A.7.5 Comprehensive Support Systems CSS Teams; Targeted Case Management Chapter 106

**Effective:** January 2, 2025

**Purpose/Intent:** The purpose of this policy is to provide direction and information on Support Coordination operational requirements and procedures. Support Coordination operations will conform to all applicable Federal and State Medicaid Waiver and Home and Community Based Services Setting rules.

**HCBS Waivers:** ID, LAH

**Key Terms:**

Home and Community Based Services (HCBS)
Person-Centered Plan (PCP)
Support Coordinator (SC)
Support Coordination Agency (SCA)
Direct Support Providers (DSP)
Targeted Case Management (TCM)
Behavior Support Plan (BSP)
Quality Improvement Plan (QIP)

**Procedures:**

1. **Support Coordination Agency Operational Requirements:** The following operational requirements are established for all Support Coordination Agencies.
   a. SCAS will comply with the operational requirements found in the Scope of Service.
   b. SCAs will comply with the Administrative Standard for 310 Boards.
   c. SCAs will provide conflict free Support Coordination/Case Management services in accordance with HCBS Setting Rule.
   d. SCAs will have written policies and procedures for recruiting and hiring staff in accordance with all applicable laws and meet requirements outlined in AC 580-5-30.
2. **Support Coordination Qualification and Training Requirements:** The following education and trainings required to be a SC:
   a. Possess a bachelor's degree in a human services field: Preference should be given for experience working with individuals with intellectual disabilities and/or working in support coordination, case management, or roles with similar responsibilities. Human Service field includes the following disciplines: Social Work, Psychology, Criminal/Juvenile Justice, Special Education, Sociology, Speech Education, Rehabilitation, Counseling, Speech Pathology, Audiology, Nursing, Physical or Occupational Therapy, and any related academic disciplines associated with the study of Human Behavior, Human Skill-Development, or Basic Human Care Needs.

b. SCs must complete a Support Coordination training program approved by DDD and the Alabama Medicaid Agency within six (6) months of beginning employment unless training is needed before the staff can safely provide the service.

3. **Effective Person-Centered Planning Practices:** The following practices are established for all SCAs
   a. SCs are to support waiver recipients to direct their own plans to the extent they desire, as well as be offered the opportunity to determine who will participate in their PCP meeting.
   b. Use of most integrated and non-disability specific setting:
      - Service selection, as part of identifying strategies to achieve the waiver recipient's desired life and defined outcomes during the person-centered planning process, will focus on community-based service options prior to exploration of residential placement or facility-based services.
      - Service delivery includes paid and unpaid services and supports by waiver and/or other service providers (e.g., Medicaid State Plan providers, ADRS providers, special/general education provider, and generic community service providers), friends, family, and other natural support networks.
   c. SCs will assist waiver recipients with maintaining eligibility for the waiver and provide education and support as needed.
   d. Assessment resources and procedures:
      - SCs will utilize assessment and planning resources and procedures approved by DMH-DDD.
        - Resources, procedures, and other training information are listed on the ADMH website: https://mh.alabama.gov/training/
      - SCAs will conduct assessments using person-centered and strength-based approaches including: involving the waiver recipient in all assessment activities; exploration (with the waiver recipient) of preferences and what works well for the waive recipient, identification of the waiver recipient's own strengths and other positive attributes, and encouragement of self-determination and self-direction. (see SC Guideline Appendix 1)
      - Assessments will be completed with the waiver recipient and, as applicable, their legally authorized representative, within 30 days of enrollment in the waiver program, prior to redetermination or change in services and thereafter as appropriate to the person, but at least annually.
        - Any identified initial health and safety concerns will be addressed within 14-days of waiver program enrollment.
      - Assessment documentation will include the waiver recipient's desired outcomes, in his/her own words, and capture the exploration of hopes and dreams from the assessment conversation.
      - Assessment documentation will include the agreed strategies to achieve the waiver recipient's desired outcomes and meet their assessed needs related to these outcomes that will appear on the PCP noting how the strategies will be implemented (including in what settings the individual selected) by the waiver recipient, natural support network, community supports, and paid services and supports. In addition, any information related to the person that address HCBS requirements (Setting Specific Transition to Compliance Plan for ID and LAH waivers) should be included.

- Assessment documentation will include exploration and determination of back-up and contingency plans for situations where identified supports associated with the defined strategies are not available, and these back-up and contingency plans will appear on the PCP.
- The SC will schedule and hold premeeting (s) with the waiver recipient, family members, and direct support providers DSP either individually or with everyone. The premeeting is to ensure that all necessary assessments and information has been provided and identify the goals/outcomes for individuals. The premeeting should occur at least 14 days prior to the Team Meeting.
- SCs will recognize all waiver recipients possess unique abilities and attributes that contribute to the achievement of their goals and independence.
    - PCPs will document the strategies agreed upon by the person from the assessment process noting how the strategies will be supported by the individual, natural support network, community supports, and paid services and supports, along with the frequency of support, units of support, and cost per unit of support.
    - Person-Centered Assessment and Planning (PCAP) will focus on the combination of the waiver recipient's strengths, needs, and community of supports in determining strategies to compliment and assist in the attainment of goals for each person to live his/her best life, as defined by the waiver recipient after exposure to all options and support for informed choice.
    - Planning needs to address all person identified, desired outcomes incorporating strengths and capacities to build on and barriers to be overcome
    - Planning will address SC or other clinical professional identified risks associated with not utilizing/building on strengths, risks identified with not overcoming barriers to desired life and outcomes, and other risks that may be identified by the SC or other clinical professionals.
    - If a waiver recipient does not agree or recognize one or more risks identified by the SCs or other clinical professionals, SCs will follow the Risk Management direction found below in this policy.
- A Team Meeting will occur, including the waiver recipient, and legal representative if applicable, to review, discuss and finalize all aspects of the PCP.
    - Members of the Team, invited to the Team Meeting, will receive a copy of the draft person-centered plan 7 business days before the Team Meeting.
    - PCPs will be finalized with the person and, as applicable their legally authorized representative within 30 days of enrollment in the waiver program. Then 30 days for updates as appropriate to the waiver recipient.
    - As required for TCM, the PCPs will be updated at least every 6 months and at redetermination (within 365 days). The PCP must be signed by all team members and uploaded in electronic database.
- The PCP is a living document, therefore changes occurring within the review period will be updated in real time within the assessment and plan. Person-centered assessments and plans, and updates to the assessments and plans, will be signed, and dated by the person, their legally authorized representative, the provider(s) responsible for implementing strategies, and the SC.

- Signed completed person-centered assessments and plans will be provided to the waiver recipient and sent to providers via email within 30 calendar days of the Team Meeting.

4. **Re-assessment and Monitoring:**
   a. SCs will assess progress as needed, but at least every 90 calendar days and document within the person-centered assessment/plan.
   b. SCs will document the level progress as needed at least every 90 calendar days within the progress note and quarterly narrative.
   c. Through interviews and observations, the SC evaluates the waiver recipient's progress toward accomplishing the goals listed in the PCP at a minimum quarterly. In addition, the SC contacts the waiver recipient, family members, friends and/or agencies providing services or supports to the individual and reviews the results of these contacts, together with the changes in the individuals needs shown in the reassessments and revises the person-centered plan if necessary.
   d. SCs will document the level of progress as needed but at least every 90 calendar days in the PCAP/PCP. If there are no changes to the services or providers needed within the PCP, then there is no need for new signatures. The SC will initial and date the signature page of the PCP indicating review of the PCAP/PCP. If there are changes to the services and or providers needed, then the SC will update the PCAP/PCP, review the updated PCP with the team and obtain all Team members' signatures on the new plan.
   e. The SC determines what services have been delivered and whether they adequately meet the needs of the waiver recipient. The PCP may require adjustments as a result of monitoring.
   f. SCs will annually assess and document updates to the PCP and assessment, minimally completing the reassessment section in the information management system.
   g. All Person-Centered Assessment and Planning guidelines outlined above are applicable to the redetermination process.

5. **Back-up and contingency planning:**
   a. Assessment and planning documentation will include back-up and contingency exploration for situations where supports of identified strategies are not available.
   b. SCs will report lack of supports for a service to the appropriate Regional Office.
   c. SCs will work with the appropriate Regional Office to build capacity for this service.
   d. SCs will research existing providers and explore the possibility of providing the service to support the person.
   e. SCs will ensure a short-term person-centered plan is developed in accordance with person-centered planning practices to support individual's receiving temporary respite supports. The short-term plan will outline what goals will be achieved, what individual's preferences, strengths, and needs are, and their back-up plan.
   f. All Person-Centered Assessment and Planning guidelines outlined above are applicable to the redetermination process.

6. **Promotion and Protection of Individual Rights and preventing abuse of waiver recipients:**
   a. SCs will implement operational practices that promote and protect the rights of waiver recipients as defined by all applicable Federal and State of Alabama regulations, laws, acts, and other legal authority.
   b. SCs and the provider agency will participate in a discussion at the annual meeting to ensure waiver recipients are informed of their rights. The SC documents the conversation and provide a copy of the Rights & Responsibilities form to the provider agency.

c. SCs will work with providers and communities to ensure waiver recipients have meaningful work and activity choices. These choices should encourage and promote age-appropriateness, a positive self-image, and consider the waiver recipients 'cultural background and/or preferences.
d. SCs will implement operational practices to ensure waiver recipients receive only the level of support needed for the waiver recipient to make their own decisions, including assisting the waiver recipient to advocate for themselves.
e. SCs will provide waiver recipients and their legally authorized representatives an oral and written summary of their rights and responsibilities and how to exercise those rights and responsibilities.
f. SCs will maintain practices for due process, including review and documentation, in the event of a proposed restriction of an waiver recipient's rights.
g. SCs will provide education and/or resources on voter registration and the voting process to people age eighteen or older that express interest and assists with registering and voting, as needed.
h. SCs obtain written informed consent from the waiver recipient or their legally authorized representative prior to:
    - Any intrusive medical or behavioral intervention,
    - Participation in research, and
    - Sharing information about the waiver recipient
i. Materials presented to waiver recipients, or their legally authorized representative is provided in language the waiver recipient can understand.
j. SCs provide individualized supports/services that are free from discrimination by race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances.

**7. Fraud, waste, and abuse:**

a. SCs will comply with all provisions of Chapter 560-X-4.04 and Chapter 560-X.4.05.
b. SCs will monitor the waiver recipient's financial situation and ensure the waiver recipients are not paying for anything covered by a waiver service.
    - Behavioral Support Plans (BSP):
    - If appropriate, waiver recipients have a BSP that reduces, replaces, or eliminates specific behaviors and are implement according to DMH-DDD's Behavioral Services Procedural Guidelines.
        - BSPs are created by the provider agency. The provider agency will submit a copy of the BSP to the SCs to be documented within the Person-Centered Assessment and Plan.
        - SC will document any restrictions or need for restraints in the Person-Centered Assessment and Plan
        - Changes to the BSP are made and implemented by the provider agency with the agreement of all team members.
    - BSPs are approved by the Support Team.
        - BSPs with level 2 or 3 procedures are reviewed and approved by the Behavior Review Committee, the Human Rights Committee, and the waiver recipient or waiver recipient's legally authorized representative.
    - BSPs are reviewed at least quarterly, or more frequently as required by the waiver recipient's needs, for effectiveness and appropriateness.

- Highly intrusive behavior interventions or punishment for the convenience of staff or in lieu of a BSP are not permitted.

8. **Crisis planning and intervention:**
   a. SCs will follow the CSS Team operation guideline.
9. **Risk Management:**
   a. Every waiver recipient has the right to make informed decisions of his/her choosing necessary for individual growth and development. SCs will support dignity of choice and risk, allowing for self-determination related to reasonable risks of personal choices.
   b. The assessment, development, planning and implementation of risk mitigation strategies are discussed and agreed upon by all team members at the annual meeting.
   c. SCs are responsible for:
      - Identifying and evaluating potential positive and negative risks associated to choices made by the individual.
      - Assess and or address risk identified through analysis of the waiver recipient's incident history via review general event record (GER). (Requirement by Alabama Medicaid Agency)
      - Identifying the waiver recipient's tolerance for accepting and taking that associated risk related to the waiver recipient's goals and preferences.
      - Development and communication of risk strategies for choices the person determines are worth accepting and taking.
      - Identifying methods and processes to monitor the effectiveness, updates, and continued use of risk mitigation strategies.
      - Documenting the risks identified and risk mitigation strategies for each waiver recipient as part of the person-centered assessment and plan.

10. **Natural Support Networks:**
    a. SCs ensure there are a variety of methods for helping waiver recipients stay connected to their natural supports.
    b. SCs will work with provider agencies to identify strategies to meet the desired level of contact with natural supports identified during the person-centered planning conversations.
    c. SCs ensure the waiver recipient is provided education to develop and/or improve skills to support the waiver recipient's communication with natural supports, especially families and friends.
11. **Conflict of interest:**
    a. SCs will avoid conflicts of interest that interfere with the timely and effective assessment, planning, and support of people enrolled in waiver programs.
    b. At a minimum, SCs and provider agencies will adhere to the Conflict Free Support Coordination/Case Management Services outlined in Scope of Service section 2.1.
12. **Collaboration:** SCs will collaborate with service and agency providers to identify, assess, and implement person-centered plans and community resources to enhance service options, and document such within the Person-Centered Assessment and Plan.
    a. SCs will maintain knowledge of applicable waiver service options, community resources, and a waiver recipient's natural supports.
    b. SCs will identify gaps in contracted service capacity for improvement and development.
    c. SCs will address any environmental and safety concerns with provider agencies and ensure education is provided to the waiver recipient on how to mitigate any safety concerns.

d. SCs will share pertinent information regarding the waiver recipient's support needs, including medical care, safety concerns, etc. with all applicable Support Team members.
e. SCs will partner with paid and unpaid service providers to identify opportunities for innovative practices to implement person-centered planning.
f. SCs will monitor the implementation of PCP strategies and partner with providers to improve effectiveness and address any training gaps.

13. **Self-Directed Services:** SCs must complete the Person-Centered Assessment and Planning Process with all self-directed waiver recipients. This includes the assessments (Appendix 1), person-centered assessment and plan.
14. **Individual Experience Assessment (IEA) Survey:** The IEA is the approved assessment that describes and measures the participant's experience with ADMH HCBS Waiver services.
    a. Support Coordination Agencies (SCAs) SCs are required to complete the IEA annually
    b. SCs are to address all "No" IEA responses in the PCP.
    c. Support Coordination Liaisons will use the Person-Centered Assessment and Plan Feedback and Monitoring tool to review PCPs to verify the IEA was completed and the issues addressed in the PCP
15. **Quality Improvement Plan:** ALL Support Coordination Providers must be in FULL COMPLIANCE with all HCBS regulations. Noncompliant findings will result in a mandated HCBS Quality Improvement Plan (QIP) developed by ADMH to be implemented by the provider.
    a. Non-compliant findings should be corrected across all settings, IEA/PCPs and other documents.
    b. Providers must respond in agreement with the HCBS QIP, and dates TA will be provided within 5 business days of receipt of plan.
    c. Providers must address ALL findings within 30 days of receiving HCBS QIP.
    d. Providers who fail to implement strategies to meet compliance will be considered noncompliant with the HCBS requirements.
    e. All Support Coordination providers must meet 100% compliance with all HCBS requirements beginning 8/1/22
    f. The ADMH-DDD will employ its progressive discipline procedures, as needed, to address any failures on the part of staff to implement actions as outlined in the QIP. Such procedures may include further staff training to termination of employment. Similarly, the ADMH-DDD will take enforcement actions, where needed, to address providers failure to perform and provide services in accordance with this QIP and related ADMH policies, procedures and operational guidelines. Such enforcement actions may range from mandated technical assistance to monetary penalties and termination of service contract. Actions may also include notification to Medicaid of areas of non-compliance.
    16. Support Coordination Agency Internal Quality Assurance
        a. The Support Coordination Agency must engage in internal quality assurance reviews of the waiver recipient's record, specifically the person-centered assessment and plan using the DDD person-centered assessment and planning feedback and monitoring tool on a quarterly basis.
        b. The SCAs will use the sample calculator to determine the sample size (within a 95% confidence interval) for the quarterly review.
        c. The SCA will enter responses to the DDD PCAP Feedback and Monitoring Tool in DDD's information and management system on a quarterly basis.

d. Support Coordination Agencies may bill for the quality assurance review of the PCAP/PCP to ensure proper documentation is in place. This billing should be coded under "Reviewing records of providers of services to ensure proper documentation is in place."

**Appendix 1**: For Self-Directed Support, the Support Coordinator is responsible for completing the assessment.

| Current Form/ Process | Provider Responsibility | SC Responsibility |
|---|---|---|
| * Functional Assessment | Complete and submit to SC | Uploads assessment into the information management system and summarizes findings for assistance with ADLs and IADLs within the barriers (core issues) section of each domain as appropriate within the PCP |
| Nursing Assessment | Complete and submit to SC | Uploads assessment into the information management system and summarizes findings within the Overall Health subsection of the Healthy Living Domain |
| *Financial Assessment or Money Management Assessment | Provide necessary information to SC | Support Coordinator completes, uploads assessment into the information management system and summarizes findings within the Finances subsection of the Community Living Domain |
| Fall Risk Assessment | Complete and submit to SC | Uploads assessment into the information management system and summarizes findings within the Safety subsection of the Community Living Domain |
| Behavior Support Plan | Complete and submit to SC | Uploads assessment into the information management system and summarizes findings within the MH & AODA subsection of the Healthy Living Domain |
| Medication Reduction Plan or Psychotropic Medication Plan | Complete and submit to SC | Uploads assessment into the information management system and summarizes findings within the Medications subsection of the Healthy Living Domain |
| *Safety Assessment | Complete and submit to SC | Uploads assessment into the information management system and summarizes findings within the Safety subsection of the Community Living Domain |
| *Rights Assessment | Provide necessary information to SC | Support Coordinator completes, uploads assessment into the information management system and summarizes findings within the Exercising Rights subsection of the Self-Determined Domain |

| | | |
|---|---|---|
| Key Assessment | Complete and submit to SC | Uploads assessment into the information management system and summarizes findings within the Access to Possessions subsection of the Community Domain |
| Lease Contract | Complete and submit to SC | Uploads assessment into the information management system and summarizes findings within the Living Situation subsection of the Community Living Domain |
| Lease Contract | Complete and submit to SC | Uploads assessment into the information management system and summarizes findings within the Living Situation subsection of the Community Living Domain |
| Employment | Provide necessary information to SC | Support Coordinator completes the employment assessment in the information management system and the employment survey. Summarizes findings within the employment section of person-centered assessment and plan. |

This list in not all-inclusive, provider agencies should continue to follow current approved administrative standards.

*These documents are always required regardless of services received. For Self- Directed Supports, the SC is responsible for completing these forms.

**Please click the links below to access forms:**

**ANNUAL FINANCIAL ASSESSMENT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Financial-Assessment.pdf

**ANNUAL FUNCTIONAL ASSESSMENT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Functional-Assessment-Form.pdf

**RIGHTS ASSESSMENT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Rights-Assessment.pdf

**ANNUAL SAFETY ASSESSMENT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Safety-Assessment.pdf

## A.4.9 FREE CHOICE OF PROVIDER

**Responsible Office:** Offices of Support Coordination
**Reference:** Administrative Code 580-5-30-.15, Operational Guideline A.2.2 Dissatisfaction of Services/ Grievance Process, Operational Guideline A.5.13 New Settings HCBS Compliance
**Effective:** Historical Practice
**Revised:** June 25, 2024

**Statement:** The Alabama Department of Mental Health - Developmental Disabilities Division (DMH-DD) requires the use of a Free Choice of Provider (FCOP) as well as the FCOP Complaint/Grievance process.

**Purpose/Intent:** The Free Choice of Provider process ensures that individual supported has the right to choose their provider or each of their services without coercion. In addition, the FCOP Complaint/Grievance process allows the individual the opportunity to report concerns or issues with the selected provider. ADMH-DDD requires the use of a Free Choice of Provider (FCOP) form as well as the FCOP Complaint/Grievance form. The FCOP format is required but may be edited to include the provider names who provide services/supports for the person. The Complaint/Grievance form may not be edited.

**Purpose/Intent:** The Free Choice of Provider process ensures that individual supported has the right to choose their provider or each of their services without coercion.

**HCBS Waivers:** ID/LAH

**Key Terms:**
FCOP (Free Choice of Provider)
SC (Support Coordination)

**Procedures:**
Free Choice of Provider
Free Choice of Provider is a requirement that must be ensured throughout the delivery of HCBS Waiver Services. Individuals receiving services must have the opportunity to choose their direct support provider and where there are multiple support coordination providers, individuals must receive choice among them.

**The Support Coordinator must:**

1. Ensure the FCOP is completed at the time of new admission and signed by all parties including the SC.
   a. For ID and LAH waiver participants, the FCOP must also be completed annually and every time the person supported changes provider.
   b. For CWP waiver participants, the FCOP is completed only at the time of new admission into waiver services.
2. Ensure the choice is as informed as possible by the offer to the person supported to arrange a visit with any provider at any time the person desires
3. Must be impartial as to choose made by the person supported and may never steer or otherwise influence the person's decision

4. Ensure signatures are obtained from both the Support Coordinator (SC) and the provider. Provide a copy of the signed document to anyone who signs the document.
5. Scan the signed form into the notes of THE INFORMATION AND MANAGEMENT SYSTEM at enrollment.
6. It is also required to be scanned into notes as a part of the redetermination packet and at the point that there is a provider change for ID and LAH waiver participants.
7. Maintain the original in a secure location as this completed form is subject to review by Alabama Medicaid and Alabama Department of Mental Health auditors.

*HCBS Noncompliance of Provider*
*If a provider is determined to not meet 100% compliance with the HCBS Settings Rule, then the Support Coordinator will be notified and must begin the process to facilitate choice for the individual.*

**Please click the link below to access form:**

**FREEDOM OF CHOICE FORM:**
https://mh.alabama.gov/wp-content/uploads/2025/05/Freedom-of-Choice-Form.pdf

# CHAPTER 5
# PROVIDER REQUIREMENTS AND OTHER INFORMATION

## A.5.1 NEW PROVIDER ENROLLMENT

**Responsible Office:** Offices of Certification
**Reference:** ADMH Administrative Code 580-3-23-.09 Certification of Community Programs; ADMH Policy 540-003, 550-001; 580-3-25 Administrative Review for the Certification of Community Programs; 580-5-30 Intellectual Disabilities Services
**Effective:** Historical Practice
**Reviewed:** January 2, 2025

**Statement:** Upon 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.

**HCBS Waivers:** ID, LAH

**Procedures:**
Phase ONE - *Overview*
1. Prospective provider completes online training

Phase TWO – *Orientation (capacity 50)*
1. 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
2. Prospective provider MUST complete entire orientation to continue process
3. Prospective provider completes application and submits it to ADMH Office of Certification Administration (OCA)
4. Prospective provider must submit application package within 1 year of attending orientation
5. OCA submits background check to Bureau of Special Investigation (BSI)
6. BSI forwards completed background check to OCA
7. 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

8. 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 individuals in the Number to be Served column.

| **Gender Served** | **Age Group** |
|---|---|
| A = Male | 1 = Children (4-12) |
| B = Female | 2 = Adolescents (13-20) |
| C = Both | 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 diploma as proof of degree (Executive Director/Owner/Operator)
2. _____ 5 years' experience with service provision to ID population in detail (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. _____ Quality Improvement 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.

1. 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:
    - Unfavorable background check for Executive Director (ED) (can reapply with new ED)
    - Falsification of information (cannot apply again)
    - Lack of educational background for Executive Director (can reapply with new ED)
    - Lack of required experience (5 yrs.) for Executive Director (can reapply with new ED)
    - Application reviewed 3 times
    - Pattern of substantiated incidents of abuse, neglect, mistreatment, and exploitation
    - Setting does not meet HCBS Settings Rule
    - Presence on the Exclusion List
    - 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)
    - Previously Decertified
    - Inappropriate name for organization (can reapply with favorable name)
2. If application package meets criteria, application is approved and sent to OCA for issuance of a Temporary Operating Authority to provide services
3. 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"*

1. Provider submits application for 'proposed' setting location to OCA

*Phase FOUR – New Provider Orientation*

2. Overview of ID Services
    a. Scope of Waiver
    b. HCBS
    c. Operational Guidelines Manual
    d. Funding and Maintaining Eligibility
    e. Waiting List/Placement
    f. Supported Employment
    g. Housing
    h. Community Integration
3. Fiscal Management
    a. Contract Process
    b. Billing and Claims
    c. IRBI
4. Community Services
    a. Provider Self-Assessments
    b. Validation/Monitoring/POA Process

c. Special Team Meeting
d. IPMS
e. Nursing
f. Regional Technical Assistance

5. Comprehensive Support Services
   a. Behavioral Support Planning
   b. Crisis Management
6. Certification
   a. Administrative Code
   b. Certification Overview
   c. HIPPA
   d. Person-Centered Planning
7. Quality Enhancement
   a. Person-Centered Thinking
   b. Fatal Five
   c. Basic Assurances (Factor 10 Training)
   d. 4-Day POM Training
8. 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
9. Advocacy & Rights Protection
   a. Rights Training/Assessment
10. 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 prior to the Medicaid beneficiary's service date. The self-assessment is to be submitted via the Information Management System to the assigned RO Monitor within 15 days of receiving the TOA, with the exception of the IEA.

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
    a. 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

**Please click the link below to access form:**

**APPLICATION AND SETTING REVIEW FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Application-and-Setting-Review-Form.pdf

## A.5.2 CERTIFICATIONS

### A.5.2.a Certification Status and Adding New Settings, Services, and/or Individuals

**Responsible Office:** Offices of Certification
**Reference:** Chapter 580-1-4 covers Administrative Standards for Providers (non-310)
**Effective:** Historical Practice
**Revised:** July 1, 2024

**Statement:** This process is a guide for community providers wanting to add new settings, new services, and/or individuals.

**Purpose/Intent:** To provide community providers with the process for adding new settings, new services, and/or individuals and the requirements relating to certification status.

**HCBS Waivers:** ID, LAH

## Key Terms:

Home and Community Based Settings Rule (HCBS):
Decertification:
Temporary Operating Authority (TOA):
Provisional Status:
Replacement Setting:
Certified Findings Quality Improvement Plan of Action:
Office of Certification Administration:

## Procedures:

1. NEW PROVIDER ENROLLMENT (NEW SETTING/NEW SERVICE):
    a. Prospective Providers completes Phase I and Phase II training, submits a complete application to ADMH Office of Certification Administration (OCA) within a year of attending orientation.
    b. The provider agency submits an application for a 'proposed setting' location to OCA and notifies the Regional Office that the setting needs to be reviewed.

2. PROCEDURES- EXISTING PROVIDER (NEW SETTING/NEW SERVICE)
   When a certified entity develops new programs or services covered by ADMH/DDD standards, ADMH/DDD must be informed of the plan in writing and adequate documentation as specified by ADMH/DDD must be submitted to permit a determination that the plans are compliant with Life Safety and/or programmatic standards established for that service/program. This plan also includes the number of beds/individuals the program is certified for.

3. PROCEDURES- CERTIFIED PROVIDER -NEW INDIVIDUALS
    a. When a provider is in Provisional Status, said provider is refrained from the following:
        - Receive referrals for individuals to serve nor accept new individuals.
        - Add a new setting.
        - Add a new service.
    b. When a provider's provisional status is removed, ADMH-DDD will only approve a 'replacement' setting if it meets all normal requirements meaning compliance with ADMH/DDD standards, basic assurances, HCBS federal setting's rule, Life Safety etc.
    c. ADMH/DDD will not approve additional settings or services, following a provisional certification, until the provider successfully completes two regular (Full programmatic) certification reviews meaning the next certification review cannot receive another provisional and the one after that cannot receive another provisional.
    d. Final determination on whether a setting is approved is made by the Office of Certification in Montgomery. Regional Offices and Support Coordination should, however, confirm the provider is in the appropriate certification status in order to add new settings, new services, and/or receive individuals to serve prior to visiting a proposed setting and/or referring someone to a setting for services.

## A.5.2.b Temporary Operating Authority (TOA) Process *(Removed) – See A.5.2.a)*

## A.5.3 NEW PROVIDER ENROLLMENT WITH ALABAMA MEDICAID AGENCY

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30-.13; Alabama Medicaid Provider Manual, OG# 4.1
**Effective:** Historical Practice
**Revision:** February 25, 2025
**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

**HCBS Waivers:** ID/LAH

**Key Terms:**
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 Certification Staff.
3. The Certification Staff 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).

## A.5.4 VALIDATION OF PROVIDER HCBS SELF-ASSESSMENT *(Repealed)*

## A.5.5 MONITORING OF WAIVER SERVICES

**Responsible Office:** Offices of Community Programs

**Reference:** ADMH Administrative Code 580-3-23-.13 through 580-3-23-.15
**Effective:** Historical Practice
**Revised:** July 1, 2024

**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.

**HCBS Waivers:** ID/LAH

**Key Terms:**
Centers for Medicare and Medicaid (CMS)
Regional Community Services (RCS)
Community Services Director (CSD)
Plan of Action (POA)
Division of Developmental Disabilities (DDD)
Support Coordination Agency (SCA)

**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 reviews the HCBS training records of Direct Support Professionals who work in a setting which is to be monitored as well as the lease and person-centered plan for at least one individual living in the setting which is to be monitored.
3. 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.
4. The Regional Monitor uses the Monitoring Tool to complete the monitoring assignment, comprehensively addressing each item included and verifying with direct observation of substantiating documentation, interviews, and/or visual inspection, recording affirmative evidence as appropriate.
5. 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.
6. The Regional Monitor will conduct an exit interview with the Direct Support Staff present in the setting, who participated in the monitoring, reviewing all findings or lack thereof. The Direct Support Staff will sign the monitoring form acknowledging that the findings were discussed.

7. The Regional Monitor completes the monitoring report and transmits to the Provider and Support Coordination Agency, Support Coordinator Supervisor, or Designee, via email within ten (10) business days, delineating those findings requiring follow-up. The CSD/designee and Regional Support Coordination Liaison is to be copied on this email.
8. If the Provider and/or SCA receives a monitoring report that requires follow-up response(s), the Provider and/or SCA must address those findings, via email, using the ADMH-DDD Settings Monitoring Tool, 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 written Provider's response as resolved.
    b. The Support Coordination Agency is responsible for addressing Sections 'Person-Centered Plan Documentation of Modifications to HCBS Requirements" and "Person-Centered Plan Documentation of Choice of Setting, Services and Supports", which encompass questions 1-12 of the ADMH-DDD Settings Monitoring Tool, using the Monitoring Tool for the response. All other Sections of the Monitoring Tool are to be addressed by the Waiver Service Provider.
        - The Provider is responsible for filling out "To Be Completed by Provider Responsible Staff/Completion Date" (for those items deemed non-compliant on the monitoring report) and signing/print name Provider Agency Executive Director (or Designee)

        - The SCA is responsible for filling out "To Be Completed by SCA Responsible Staff/Completion Date" (for those items deemed non-compliant on the monitoring report) and signing/print name Support Coordination Agency Executive Director (or Designee)
    c. If there are findings that require more than 10 business days to resolve, the Provider and/or SCA is required to submit to RCS within the allotted 10 business days the completed ADMH-DDD Settings Monitoring Tool for those findings, to include method, responsible staff, and specific time frame of resolution.
    d. Each Section must be answered in its entirety, either as non-applicable or in the affirmative for the setting to be determined compliant with the corresponding HCBS Settings Rule.
9. 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. Regional Monitor will notify Provider and SCA via email of setting status and will update the HCBS Compliance Tracking Spreadsheet, and the Statewide Census Spreadsheet located in Microsoft Teams will be updated by Community Services staff.
10. If the Provider and/or SCA 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 and/or SCA's specified time frame(s), the Regional Monitor transmits a single prompt to the Provider and/or SCA 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 and/or SCA does not respond to this prompt within five (5) business days, the Regional Monitor will notify the CSD/designee (if applicable) on the sixth business day. The CSD/designee will transmit a prompt via email to the Executive Director of the Provider and/or SCA requesting final resolution, within two business days of notification by the Regional Monitor.

b. If the Provider and/or SCA does not respond to this prompt within five (5) business days, the CSD will meet with the designee (if applicable), the Regional Monitor, the Regional Support Coordination Liaison (if applicable), the Regional Certification Staff and the Regional Quality Enhancement Staff to review the unresolved findings and to identify appropriate topics of Technical Assistance for the Provider and/or SCA.
c. The Regional Office will require the Provider and/or SCA to participate in the assigned Technical Assistance and then resolve the outstanding findings/provide substantiating evidence within 30 days.
d. If the Provider and/or SCA does not satisfactorily resolve all findings following provision of Technical Assistance, the provider's and/or SCA's initial Monitoring Report and POA (if applicable) will be reviewed by the CSD for recommendation for the Setting Certificate to be revoked by DMH certification and the SCA to be placed in Provisional Certification Status. If revoking the Certificate is warranted, the individuals in the setting will be offered choice of other living arrangements and the setting closed.
e. The setting will remain closed and if applicable the SCA in Provisional Certification status until HCBS compliance is achieved.

11. For accountability purposes, the CSD/designee maintains a database of expected and actual Provider and/or SCA response/POA receipt dates.

## A.5.6 MONITORING OF SPECIAL STAFFING *(under review)*

**Responsible Office:** Offices Regional Community Programs
**Effective:** Historical Practice
**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.

**HCBS Waivers:** ID/LAH

**Definitions:**
Request for Action (RFA)
Community Services Specialist (CSS)
General Event Report (GER)
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 individuals 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.

## A.5.7 REGIONAL PROVIDER MEETINGS

**Responsible Office:** Offices of Community Programs
**Reference:** Administrative Code 580-5-30-.02
**Effective:** March 3, 2025

**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

**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.

## A.5.8 PROVIDER NAME CHANGE PROCESS

**Responsible Office**: Offices of Certification
**Reference**: ADMH Administrative Code
**Reviewed/Revised Date(s):** January 30, 2025
**Statement:** To provide ADMH providers with a process to change the name of their organization.
**Purpose/Intent:** To provide ADMH providers with a process to change the name of their organization.

**Scope:** Office of Provider Certification, Office of Certification Administration, Fiscal Office, Office of Contracts Office.

**Key Terms:**
Division of Developmental Disabilities
Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DDD)

**Procedures:**
1. Provider contacts the Office of Provider Certification in writing to discuss the appropriateness of the proposed name change prior to contacting IRS to assist the provider with an appropriate name.
2. The Office of Provider Certification contacts the Provider in writing of the preliminary approval of the name change.
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 two-page application to request a name change.
6. The OCA forwards application and supporting paperwork to DD Certification and cc's the Contracts Office and Fiscal Office. 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 the application then 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 Bureau of Finance Office.
11. The Finance Office reviews, 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.

## A.5.9 NEW SYSTEMS SOFTWARE RELEASES *(Under Review)*

**Responsible Office:** Offices of System Management
**Reference:** DDD Information Management System Manual
**Effective:** Historical Practice

**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

**HCBS Waivers:** ID/LAH

**Key Terms:**
DDD IMS (Division of Developmental Disabilities Information Management System)

**Procedures:**
1. The ADIDIS IT Project Manager is notified and is provided the Release Notes by the vendor.
2. Once received, ADIDIS Support Team 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://hssalstage.wellsky.com/acceptance-humanservices/Pages/Login.aspx?ReturnUrl=%2Facceptance-humanservices
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 ADIDIS Support Team 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. IT Project manager will notify the IT change control board on the schedule and the downtime when the new features are being deployed.
8. Once new features are deployed, ADIDIS support team will verify the new features on the live site before notifying the users .
9. All Users will be notified in advance by the ADIDIS IT project manager on the anticipated downtime when the new features are deployed to the live site.
10. The ADIDIS IT Project Manager will issue an e-mail for all system users as notification of the changes and/or updates in the system.

## A.5.10 DIRECT SERVICE PROVIDER OPERATIONAL REQUIREMENTS REGARDING PERSON-CENTERED PLANNING PROCESS

**Responsible Office:** Offices of Support Coordination
**Reference:** Alabama Administrative Code 580-5-30, 580-1-4, 580-3-2, 580-2-5, 580-3-22,580-3-23, 580-3-26, OGA.4.7 Conflict Free Support Coordination/Case Management Services, OG A.4.8 Support Coordination Guidelines, OG A.6.2 Provider Training and Technical Assistance, OG A.7.5 Comprehensive Support Systems CSS Teams, Home and Community Based Settings Requirements from the Code of Federal Regulations
**Effective:** February 1, 2022
**Revised:** January 3, 2025

**Statement:** Person-Centered Planning invites everyone to organize the person's supports and services, so they can live the kind of life they want for themselves.
Purpose/Intent: The purpose of this guideline is to provide direction and information on non-support coordination agency provider roles. Providers will conform to all applicable Federal and State Medicaid Waiver and Home and Community Based Services Setting rules.

**HCBS Waiver:** ID, LAH

**Key Terms:**
Person-Centered Plan (PCP)
Home and Community Based Services (HCBS)
Incident Prevention Management System (IPMS)
Individual Experience Assessment (IEA)
Support Coordination Agencies (SCA)
Support Coordinators (SC)
Quality Improvement Plan (QIP)

**Procedures:**
1. Provider Agency Operational Requirements: (See the Assessment Tools for the Certification Operational Guidelines) The following operational requirements are established for all Provider Agencies to support person-centered planning practices.
   a. Promotion and Protection of Individual Rights:
      - The provider agency implements policies and procedures that clearly define its commitment to and addresses the promotion and protection of individual rights.
      - The provider agency participates in the discussion at the annual meeting to ensure people are informed of their rights. The Support Coordinator documents the conversation and provides a copy of the Rights & Responsibilities form to the provider agency.
      - The provider agency provides individualized supports/services that are free from discrimination (race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances).
      - The provider supports individuals to make their own decisions about their supports and services and ensures decision-making supports are provided to people as needed.
      - The provider ensures services optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
      - The provider ensures all staff are trained to recognize and honor people's rights.
      - The provider agency upholds due process requirements and follows applicable procedures.
      - The provider agency implements a formal grievance policy and procedure and informs individuals of the policy annually.
      - The provider agency has access to a working and effective Human Rights Committee.
   b. Dignity and Respect:
      - Provider agency policies and procedures ensure people are treated as people first.
      - Provider agency staff respect the concerns of individual's supported and have a system in place to respond to the individual's concerns accordingly.
      - Provider agency ensure individuals have privacy in their sleeping or living unit.

- It is a requirement that all living units have lockable doors to individuals' private quarters and that individuals have been offered a key for their personal use; however, an individual does have the option to reject using the lock or refrain from obtaining a key. Only appropriate staff will have access to individual's keys to private quarters.
  - ❖ If for any reason the individual chooses to not have a key to the private living quarters, the PCP must document that the individual was offered a key, as well as any needed supports needed for the use of the key, and the reason for the choice.
  - ❖ Individuals sharing units have a choice of roommates in that setting.
  - ❖ Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

- Providers ensure all supports and services enhance dignity and respect and that individuals are free from coercion and restraint.
- Providers work with Support Coordinators and communities to ensure people have meaningful work and activity choices.
- Providers ensure the setting is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree as people not receiving Medicaid HCBS.

c. Protection from Abuse, Neglect, Mistreatment and Exploitation
- The Provider agency implements policies and procedures that define, prohibit, and prevent abuse, neglect, mistreatment, and exploitation and ensure support staff are properly trained.
- The Provider agency follows reporting and investigation requirements, including notification to Support Coordination agencies, for allegations or suspected incidents of physical, verbal, sexual or psychological abuse, mistreatment, neglect, or exploitation regardless of age.

d. Best Possible Health:
- The provider agency ensures people have support and access to manage their own health care.
- he provider agency ensures health needs are addressed in a timely manner.
- Provider agency staff immediately recognize and respond to medical emergencies and inform Support Coordinators about any changes in health status
- The provider agency ensures people receive medications and treatments safely and effectively.
- The provider agency has policies and procedures that are in accordance with the Alabama Board of Nursing Regulations.

e. Safe Environments:
- The provider agency provides individualized safety supports as outlined within the PCP.
- The provider agency protects people from abuse, neglect, mistreatment, and exploitation and follows all procedures within the IPMS.
- The provider agency ensures the physical environment promotes people's health, safety, and independence.
- The provider agency has individualized emergency plans.
- The provider agency conducts routine inspections to ensure environments are sanitary and hazard free.

- The provider agency ensures staff are qualified for their roles and implements an ongoing staff development program.

f. Staff Resources and Supports:
   - The provider agency ensures staff are trained on Quality Improvement, PCP foundations, and PCP implementation strategies.
   - The provider agency implements a system for staff recruitment and retention that is in accordance with all applicable laws and agency requirements.
   - The provider agency implements policies and procedures that promote continuity and consistency of staff.

g. Positive Services and Supports:
   - The provider agency ensures people are informed about the services and supports they provide.
   - The provider agency providers continuous and consistent services and supports for each person as outlined in the PCP.
   - The provider agency monitors and reports the effectiveness of each support and service they provide as outlined within the PCP.
   - The provider agency provides positive behavioral supports to people and ensures people are free to unnecessary, intrusive interventions.
   - The provider agency treats people with psychotropic medications for mental health needs consistent with standards of care.

h. Continuity and Personal Security:
   - The provider agency has a governing board and leadership team that provides transparent guidance and direction
   - The provider agency has clear mission and value statements aligned with person-centered planning philosophy they are accountable to.
   - The provider agency supports people to manage and access their personal money and reports details about how money was spent to the Support Coordination agency.
   - The provider agency has business, administrative, and support functions that comply local, state, federal requirements.
   - The provider agency has a cumulative record of personal information that upholds confidentiality and promotes continuity of services.

i. Quality Improvement System:
   - The provider agency has a comprehensive plan and system outlined to measure the success of the organization in meeting its desired outcomes and the outcomes outlined within the Quality Improvement Tool.
   - The provider agency has monitoring data that is accessible and used for continuous learning and improvement.

j. Conflict of interest:
   - Provider agencies have a conflict-of-interest policy and procedure.
   - Provider agency staff will avoid conflicts of interest that interfere with the timely and effective assessment, planning, and support of individuals who receive services from their agency.

2. Effective Person-Centered Planning Practices: The following practices are established for all Provider Agencies in collaboration with the Support Coordinator:
    a. Use of most integrated setting as documented in the Person-Centered Plan:
        - As part of identifying strategies to achieve the individual's desired life and defined outcomes during the individual's person-centered planning process, the team will focus on community-based service options prior to exploration of residential placement or facility-based services.
        - Service delivery includes paid and unpaid services and supports by waiver and/or other service providers (e.g., Medicaid State Plan providers, ADRS providers, special/general education provider, and generic community service providers), friends, family, and other natural support networks.
    b. Assessment resources and procedures:
        - Provider agencies will utilize assessment and planning resources and procedures approved by ADMH-DDD. A list of the documents required to be completed is listed in Appendix 1 below. All forms listed are to be completed, as applicable, to each person/situation and will be provided to the Support Coordinator at least 30-days prior to the PCP meeting.
            - Resources, procedures, and other information related to the Providers role and the Support Coordinator's role in person-centered planning are listed on the ADMH website: https://mh.alabama.gov/training/
        - Providers Agencies will provide information in a strength-based way to the Support Coordination agencies during the person-centered planning discussions.
        - Providers (a Qualified Developmental Disability Professional) will be an active participant in person-centered planning conversations and attend the pre-meeting and Team Meeting. They will provide information during the initial 30 days a waiver participant is enrolled, every time there is a change in condition, and minimally every 90 days after that.
            - If the plan is not available, the provider agency must show documented evidence of efforts to obtain the documentation.
        - Providers will provide information to support the person-centered planning process to the Support Coordination agency including:
            - Any information to identify a person’s outcomes, hopes, or dreams.
            - All possible strategies to achieve an individual's desired outcomes and how those strategies will be implemented by the individual, natural support network, community supports, and paid services and supports.
            - Information to support back-up or contingency planning should any services or supports be unavailable for any reason.
            - All assessment forms as applicable for redetermination to each person/situation should be provided to Support Coordinator at least 30 days prior to the Team meeting. With a new admission to the waiver provider should complete the assessments and submit to Support Coordinator within 14- days of admission.
            - Any other information they have related to personal or health information from outside sources.
            - Any information related to the person that address Home and Community Based Settings requirements (Residential and Day Habilitation Setting Specific Transition to Compliance Plan).

- Providers are expected to actively participate in the person-centered planning process which includes discussing assessments, providing strategies to support outcome/goals and communicating all updates to the Support Coordinator.
    - Providers are to participate in the Premeeting at least 14-days prior to Team Meeting to provide clarity about the information in the assessments and begin the outcome development for the person-centered plan.
    - Providers are to participate in the Team meeting by sharing their strategies to support individual in obtaining his/her outcomes.
    - Providers are to share quarterly updates with data identifying progress towards the goals
- Within 30 days after the Person-Centered Plan (Redetermination) Team meeting has been completed, a copy of the person-centered plan and assessment will be emailed to the provider agency. The provider will sign the person-centered plan and return a copy to the Support Coordination agency. The provider will implement the agreed upon strategies, including but not limited to the person-centered plan. The provider will report progress towards goals at least every 90 days.

c. Natural Support Networks:
- Provider agencies ensure there are a variety of methods for helping people stay connected to their natural supports.
- Provider agencies will work with the Support Coordinator to identify strategies to meet the desired level of contact with natural supports identified during the person-centered planning conversations.
- Provider agencies ensure staff and volunteers are provided training to develop and/or improve skills to support people's communication with natural supports, especially families and friends.

d. Behavioral Support Plans:
- If appropriate, individuals have a Behavior Support Plan that reduces, replaces, or eliminates specific behaviors and are implemented according to ADMH-DDD's Behavioral Services Procedural Guidelines.
    - Behavior Support Plans are created by the provider agency in partnership with the Support Coordinator and documented within the Person-Centered Assessment and Plan.
- Behavior Support Plans are approved by the individual's Support Team.
    - Behavior Support Plans with level 2 or 3 procedures are reviewed and approved by the Behavior Review Committee, the Human Rights Committee, and the individual or individual's legally authorized representative.
- Behavior Support Plans are reviewed at least quarterly, or more frequently as required by the individual's needs, for effectiveness and appropriateness.
- Highly intrusive behavior interventions or punishment for the convenience of staff or in lieu of a Behavior Support Plan are not permitted.

e. Crisis planning and intervention:
- Provider agencies will follow the CSS Team operation guideline found in OG A.7.5.

f. Risk Management:
- Every person has the right to make informed decisions of their choosing necessary for individual growth and development. Provider agencies will support dignity of choice and risk, allowing for self-determination related to reasonable risks of personal choices.

- Provider agencies are responsible for:
  - Identifying and evaluating potential positive and negative risks associated to choices made by the individual.
  - Identifying the person's tolerance for accepting and taking that associated risk related to the person's goals and preferences.
  - Development and communication of risk strategies for choices the person determines are worth accepting and taking.
  - Identifying methods and processes to monitor the effectiveness, updates, and continued use of risk mitigation strategies.
  - Communicating any risks identified and risk mitigation strategies for each individual to the Support Coordinator as part of the person- centered assessment and plan.

3. Collaboration: Provider agency staff will collaborate with Support Coordinators and other service providers to identify, assess, and implement person-centered plans and community resources to enhance service options.
   a. Provider agencies will partner with paid and unpaid service providers to identify opportunities for innovative practices to implement person-centered planning.
   b. Provider agencies will monitor the implementation of person-centered plan strategies and partner with Support Coordinators and other providers to improve effectiveness and address any training gaps.
4. Individual Experience Assessment (IEA) Survey: The IEA is the approved assessment that describes and measures the participant's experience with ADMH HCBS Waiver services.
   a. Support Coordination Agencies (SCA) Support Coordinators (SC) are required to complete the IEA annually and when the individual moves to a new setting.
   b. Support Coordinators are to address all "No" IEA responses in the PCAP/PCP.
   c. The Provider agency must provide relevant information to the Support Coordinator about the setting and the individual's access, which must be included in the PCAP/PCP.

5. ALL Direct Service Providers must be in FULL COMPLIANCE with all HCBS regulations. Noncompliant findings will result in a mandated HCBS Quality Improvement Plan (QIP) developed by ADMH to be implemented by the SCA.
   a. Non-compliant findings should be corrected across all settings
   b. Providers must respond in agreement with the HCBS QIP and dates TA will be provided within 5 business days of receipt of plan.
   c. Providers must address ALL findings within 30 days of receiving HCBS QIP.
   d. Providers who fail to implement strategies to meet compliance will be considered noncompliant with the HCBS requirements.
   e. ADMH-DDD will employ its progressive discipline procedures, as needed, to address any failures on the part of staff to implement actions as outlined in the Quality Improvement Plan. Such procedures may include further staff training to termination of employment. Similarly, ADMH-DDD will take enforcement actions, where needed, to address providers failure to perform and provide services in accordance with this Quality Improvement Plan and related ADMH policies, procedures and operational guidelines. Such enforcement actions may range from mandated

technical assistance to monetary penalties and termination of service contract. Actions may also include notification to Medicaid of areas of non-compliance.

**Please click the links below to access forms:**

**ANNUAL FINANCIAL ASSESSMENT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Financial-Assessment.pdf

**ANNUAL FUNCTIONAL ASSESSMENT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Functional-Assessment-Form.pdf

**RIGHTS ASSESSMENT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Rights-Assessment.pdf

**ANNUAL SAFETY ASSESSMENT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Safety-Assessment.pdf

**PCP TIMELINE FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/PCP-Timeline.pdf

**Appendix 1:**

| Current Form/ Process | Provider Responsibility | SC Responsibility |
|---|---|---|
| * Functional Assessment | Complete and submit to SC | Uploads assessment into ADIDISand summarizes findings for assistance with ADLs and IADLs within the barriers (core issues) section of each domain as appropriate within the PCP |
| Nursing Assessment (include self-administration of medication) | Complete and submit to SC | Uploads assessment into ADIDISand summarizes findings within the Overall Health subsection ofthe Healthy Living Domain |
| * Financial Assessment or Money Management Assessment | Provide necessary information to Support Coordinator | Support coordinator completes and uploads assessment into ADIDISand summarizes findings within the Finances subsection of the Community Living Domain |

| | | |
|---|---|---|
| Fall Risk Assessment (may bepart of nursing assessment) | Complete and submit to SC | Uploads assessment into ADIDISand summarizes findings within the Safety subsection of the Community Living domain |
| Behavior Support Plan | Complete and submit to SC | Uploads assessment into ADIDISand summarizes findings within the MH & AODA subsection of the Healthy Living Domain |
| Medication Reduction Plan or Psychotropic Medication Plan | Complete and submit to SC | Uploads assessment into ADIDISand summarizes findings within the Medications subsection of the Healthy Living Domain |
| * Safety Assessment | Complete and submit to SC | Uploads assessment into ADIDISand summarizes findings within the Safety subsection of the Community Living Domain |
| Rights Assessment | Provide necessary information to Support Coordinator | Support Coordinator Completes, uploads assessment into ADIDIS and summarizes findings within the Exercising Rights subsection of the Self-Determined Domain |
| Key Assessment | Complete and submit to SC | Uploads assessment into ADIDISand summarizes findings within the Access to Possessions subsection of the Community Living domain |
| Lease Contract | Complete and submit to SC | Uploads assessment into ADIDISand summarizes findings within the Living Situation subsection of the Community Living domain |
| Employment | Provide necessary information to Support Coordinator | Support Coordinator completes the employment assessment in ADIDIS and the employment survey. Summarizes findings within the employment section of person- |

| | | |
|---|---|---|
| | | centered assessment and plan. |
| This list is not all-inclusive list, provider agencies should continue to follow current approved administrative standards. Providers will also provide a summary of the physical results, including Aims.<br><br>* These documents are always required regardless of services received. For Self- Directed Supports, the Support Coordinator is responsible for completing these forms.<br>Appendix 2: PCP Timeline (See Attached)<br>Appendix 3: Functional Assessment (See Attached)<br>Appendix 4: Financial Assessment (See Attached)<br>Appendix 5: Rights Assessment(See Attached)<br>Appendix 6: Safety Assessment (See Attached)<br>Appendix 7: Employment Survey (See Attached) | | |

## A.5.11 HCBS: PROVIDER OWNED AND CONTROLLED PROPERTIES

**Responsible Office:** Offices of Community Programs
**Reference:** Intellectual Disabilities (ID) Waiver Appendix F; ADMH Administrative Code: 580-5-30.08(2); Federal Centers for Medicare and Medicaid Services (CMS) has determined that Home and Community-Based Services (HCBS) settings must have all of the qualities specified in 42 CFR §441.301(c)(4); OG 6.3.b. Promotion and Protection of Individual Rights
**Effective:** February 9, 2023

**Statement:** CMS has determined that HCBS settings must have all of the qualities specified in 42 CFR §441.301(c)(4) (i-v), based on the needs of the individual as indicated in their Person-Centered Plan (PCP). For provider-owned or controlled residential settings that serve individuals who are enrolled in an ADMH-DDD HCBS Waiver program, additional conditions specified in 42 CFR §441.301(c)(4)(vi)(A) through (E) must be met. Specifically, the unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. The State must ensure that a lease, residency agreement or other forms of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. For individually controlled units, tenants are expected to sign a lease with landlords.

**Purpose/Intent:** This OG defines "Provider-owned or controlled setting" for the purposes of HCBS Waiver services administered through ADMH--DDD. This OG establishes standards to ensure that HCBS Waivers administered by the ADMH-DDD maximize opportunities for enrolled individuals to access the benefits of community living and receive services in the most integrated setting. The OG further outlines the requirement for ADMH-DDD's HCBS Waiver Service residential providers to ensure a legally enforced agreement – lease/rent or residency agreement - with the individual, and guardian if applicable, is in effect when the individual resides in a provider-owned or controlled setting. This OG also outlines the components of said agreement to include the HCBS regulatory requirements for provider owned and/or controlled settings where waiver participants receive residential waiver services.

**HCBS Waiver:** ID, LAH, CWP

**Key Terms:**
Provider-owned or controlled setting
Residency Agreement
Room and Board
Residential Home
Provider
Tenant
Legal representative
Fair Market Rent (FMR)
Appeals Process for Adverse Actions
Request for Action (RFA)
Home and Community Based Services (HCBS)
Alabama Department of Mental Health-Division of Developmental Disabilities (ADMH-DDD)

**Procedures:**
1. Person-Centered Plans must reflect that the Individual was provided choice of non-disability settings.
2. Person-Centered Plans must support the Individual's/tenant's choice of provider and Residential Home among other providers and settings to include non-disability options.
3. Lease/Rent or Room & Board charges when provider owns or controls property:
    a. A specific monthly amount must be established for rent/room and board charges as determined by the following:
        - Documentation must reflect rent consistent with Fair Market Value (FMV) in the City/location of the property and rent must be fairly allocated among others considered residents in the Residential Home. To determine FMV use the following link https://www.rentdata.org/states/alabama/2022
        - Room and board refer to the cost for the provision of meals, a unit or room to sleep, laundry, basic utilities, and housekeeping. It does not mean direct support for daily living skills. Providers should regularly calculate room and board expenditures and ensure those costs are fairly allocated among the number of individuals in the setting.
        - Any damages determined to be in excess of normal wear and tear attributed to individual/tenant will result in a Person-Centered Planning Support Team meeting to determine the most equitable resolution. If damages are the result of

challenging/destructive behavior, the support team will develop a Behavior Support Plan which will be reviewed and approved by both a Behavior Support Plan (BSP) Review Committee and a Human Rights Committee (HRC), consistent with the State of Alabama Department of Mental Health rules, standards and regulations.

4. Provider Expectations:
   a. When a residential setting is owned or controlled by a provider agency, as defined above, the provider must ensure a written lease and/or residency agreement is in place for each individual/tenant served in the setting.
   b. The Division has developed lease/rental or residency agreement guidelines that are attached to this OG. Providers lease and or residency agreement must include all requirements as described in the attached guidelines.
5. Modification of the Requirements:
   a. As an individual receiving services in a HCBS setting, the individual is afforded the rights as authorized by 42 CFR 441.301(c)(2)(xiii) & 42 CFR 441.530(a)(1)(vi)(F). There may be times when, due to health and safety risks, a right may be limited. A limitation to any of these rights will always be based on a specific assessed need and will not be implemented without the individual's informed, written consent or the informed, written consent of the individual's legal guardian.
   b. If a modification of an individual's rights in the lease/residency agreement is deemed required, it must be justified through the PCP. Further, implementation strategies and the modification must be reviewed by the provider's HRC.
   c. Rights modifications should apply only to the individual with the need for the modification. In addition, no rights modification should be implemented solely because it is convenient for the provider, or legal guardian, if applicable. Implementing a modification without consent of the individual and legal guardian if applicable, is prohibited.

**Please click the link below to access the form**:

**RENT RESIDENCY GUIDE FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Rent-Residency-Guide-Form.pdf

## A.5.12 SPECIALIZED SERVICE PROVIDER ENROLLMENT

**Responsible Office:** Office of Certifications
**Reference:** 580-5-30-.01 Purpose; 580-5-30-.08 Community Service Provision; 580-5-30-.15 Freedom of Choice; ADMH Medicaid Waiver Programs; Waiver Provider Manual
**Effective:** July 1, 2023

**Purpose/Intent:** To provide a step-by-step process to a prospective provider, currently not a certified waiver provider by the Alabama Department of Mental Health, in becoming qualified to deliver specialized services and supports. Prospective providers for Specialized Services cannot also be certified waiver service providers with ADMH-DDD.

**HCBS Waiver:** ID, LAH, CWP

**Key Terms:**

Specialized Medical Supplies (SMS)
Environmental Accessibility Adaptations (EAA)
Personal Emergency Response System (PERS)
Community Waiver Program (CWP)
State of Alabama Accounting and Resource System (STAARS)
Alabama Division of Intellectual Disabilities Information System (ADIDIS)
Provider Network Manager (PNM)
Person-Centered Plan (PCP)
Positive Behavior Supports (PBS)
National Provider Identifier (NPI)

**Procedures:**

Personal Energy Response System (PERS) Level 1-3, and Remote Support services desiring to conduct business with (ADMH/DDD).

This application is for waiver service providers who are not certified by the Alabama Department of Mental Health, Division of Developmental Disabilities (ADMH/DDD) and/or for businesses which are vendors of waiver-covered items such as Assistive Technology, Specialized Medical Supplies (SMS), Home Modifications, Environmental Accessibility Adaptations (EAA), Speech and Language Therapy, Occupational Therapy, Physical Therapy Personal Energy Response System (PERS) Level 1-3, and Remote Support services desiring to conduct business with (ADMH/DDD).

1. The prospective specialized service provider completes the Waiver Service Provider/Vendor Application and submits it to the Provider Network Manager (PNM) at ADMH.
    a. Additional required documents to be included with application:
        - Copy of AL Business License (if applicable)
        - Registration with the AL Secretary of State
        - Proof of Liability Insurance
        - Certifications (if applicable)
        - Positive Behavior Supports (PBS) Level 1-3
        - Level 1 Provider – Either a Ph.D. or MA Certified as a Behavior Analyst Certification Board
        - Level 2 Provider – Either a Ph.D. or MA in Behavior Analysis, Special Education or related field and 3 years' experience working with persons with Developmental Disabilities. Level 2 providers with a doctorate do not require supervision. Level 2 providers who do not have a doctorate require supervision at 1hr per week.
        - Level 3 Provider – Either a Qualified Developmental Disabilities Professional (QDDP) as required in 43 CFR 483.430 or be a Certified Assistant Behavior Analyst (BCaBA). Level 3 Providers must be supervised by either a Level 1 or Level 2 doctorate provider at one hour per week.
        - Each prospective provider will need to register for a National Provider Identifier (NPI) Enumerator.
        - Each prospective provider will need to enroll in the State of AL Accounting & Resource System (STAARS) https://vendors.alabama.gov/

*Alabama Medicaid Agency Guidance on Waiver Background Checks*

Applicants must not have convictions or pending charges for:

- Any crime of violence
- Any felony convictions as well as any pending felony arrests

The following are criminal convictions that would deny a prospective provider from becoming a provider:

- Reckless endangerment in the past 5 years
- Stalking in the second degree in the past 5 years
- Criminal trespass in the first degree in the past 5 years
- Violating a protective order in the past 3 years
- Unlawful contact in the first degree in the past 3 years
- Criminal mischief in the first degree in the past 7 years
- Unlawful contact in the second degree in the past year

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

## A.5.13 NEW SETTINGS HCBS COMPLIANCE

**Responsible Office:** Offices of Community Programs
**Reference:** ADMH Administrative Code 580-3-23-.08 (1) & (7); ADMH Policy 550-001 Effective: July 1, 2023

**Purpose/Intent:** Ensure that Settings that receive Waiver Funding must be and maintain HCBS Compliance

**HCBS Waiver:** ID, LAH

**Definitions:**
Temporary Operating Permit (TOA)
Regional Community Services (RCS)
Alabama Medicaid Agency (AMA)
310 Authority for Targeted Support Coordination (TSC)
Individual Experience Assessment (IEA)
Support Coordination Services (SCS)
Person-Centered Plan (PCP)

**Procedures:**
HCBS Settings Rule Compliance (MUST MEET 100% COMPLIANCE)

1. The completed HCBS Compliance Checklist is to be submitted via the Information Management System to the assigned Community Services Monitor within 15 days of receiving the TOA or replacement certificate, with the exception of the IEA.

2. Community Service Monitors will review the HCBS Compliance Checklist for the assigned setting in DDD IMS.
   a. If the HCBS Compliance Checklist is incomplete or is not submitted by a Provider:
      - The Provider will be notified in writing of the need to immediately complete and submit the HCBS Compliance Checklist
      - If no HCBS Compliance Checklist is submitted within 5 business days, a second letter will be generated for the Provider, outlining the contractual consequences of failure to comply with the HCBS Compliance mandate.
      - If no HCBS Compliance Checklist is submitted by 90 days of issuance of the TOA, the TOA is revoked.

3. Community Services Monitors will make all necessary arrangements with the Provider to:
   a. Review the required documentation that supports the Compliance Checklist.
   b. Community Services Monitors will complete the HCBS Monitoring visit, enter the Monitoring Findings into DDD IMS, including findings requiring Provider action, and provide a copy of the report to the Provider within 10 days.
   c. The Provider will have 10 business days to complete the HCBS Monitoring response providing methods and timeframes for resolving all findings for the setting demonstrating non-compliance or partial compliance with the HCBS Settings Rule.
   d. Upon receipt, the Community Services Monitor reviews the HCBS Monitoring response to ensure that it adequately addresses all findings and then submits it to the CSD/designee.
      - If the HCBS Monitoring response does not address all non-compliant findings or does so inadequately, the Community Services Monitor provides that feedback to the Provider via email within 5 business days, copying the Community Services Director (CSD)/designee. The Provider then has 5 business days from the date this feedback is delivered to correct the plan and re-submit.
      - The Community Services Monitor will contact the Provider about the revised plan within 5 business days.
   e. If the Provider comprehensively resolves some findings prior to submission of the HCBS Monitoring response these findings must be reflected in the written Provider's response as resolved in the Corrective Action Plan with date and method of resolution, along with accompanying substantiating documentation.
   f. If the Corrective Action Plan is not submitted, the Community Services Monitor will inform the Community Services Director/designee on the 11th day, and the CSD/designee will contact the Provider immediately to request submission.
   g. In the event the HCBS Monitoring response is not submitted, OR documentation requested to substantiate specific compliance is needed for DDD approval and there has been no response from the provider, a certified letter informing the provider of the unresolved items, the need for additional substantiating information will be mailed requesting a response within 10 business days.
   h. Once the HCBS Monitoring response is received and deemed complete by the Community Services Monitor, they will notify the CSD/designee that it is available for review.
   i. The CSD/designee will review/approve the Provider HCBS Monitoring response within 5 business days of receipt of the completed plan.

j. If the Setting HCBS Monitoring response is not submitted or is not accepted upon resubmission, within 90 business days of the issuance of the TOA/replacement certificate, it will be revoked.

4. Provider will have met all HCBS Settings Rule criteria, as applicable, prior to the Medicaid beneficiary's service date. Provider should have met all HCBS Settings Rule criteria, as applicable, prior to the Medicaid beneficiary's service date.
5. 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).
6. 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 and Support Coordination Liaison in the information and management system for HCBS Settings Compliance review. The RO monitor completes validation within 60 days of the provider completing the HCBS Compliance Checklist. The provider then has 30 days to make corrections that meet expectations for 100% compliance.
7. At 90 days, if provider does not meet 100% compliance with the HCBS Settings Rule, the TOA/replacement setting certificate is withdrawn, and Emergency facilitation of CHOICE meetings begin.
8. At 90 days, if provider meets 100% compliance with the HCBS Settings Rule, the TOA/replacement certificate remains in good standing.
9. Certification completes a review of the TOA setting before the end date of the 6-month certification; If the TOA is revoked, Certification will not proceed with the 6-month review.
   a. For new provider, full review is conducted once an individual has been admitted before the end of the TOA.
   b. For established provider, a review of the TOA setting is conducted once an individual has been admitted before the end of the TOA certificate date. If all qualifications are met, the setting is aligned with the agency's certification date.
10. HCBS Settings Rule compliance monitoring continues with 6-month monitoring visits.

# CHAPTER 6
# CERTIFICATIONS

## A.6.1 CERTIFICATION SITE REVIEW

**Responsible Office:** Offices of Quality and Planning/Offices of Certification
**Reference:** Administrative Code 580-5-30
**Effective:** Historical Practice

**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 individuals with developmental/intellectual disabilities.

**HCBS Waiver:** ID/LAH

**Key Terms:**
Factor
Indicator
Probe

**Procedures:**
It is strongly recommended providers complete a self-assessment using the "Assessment Tool for Certification," 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.

**Important Notice: In an effort to provide due diligence in ensuring ADMH Division of Developmental Disabilities (DDD) is in full compliance of regulatory requirements related to the Home and Community-Based Services (HCBS) Settings Rule, as evidenced by its ongoing provider self-assessments, validation, and transition to compliance requirements process, DDD is suspending approval of any new requests for deemed status at this time. In consideration of the CMS requirement to continue to ensure HCBS Settings compliance, the Division will assess the merits of removing the suspension of deemed status at a later date, but not before March 2023, the date all states must be in full compliance with the HCBS Settings Rule.**

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 individuals supported to use during the review.
    - If the population of the organization is 30 or less, the sample will be 2 individuals.
    - If the population of the organization is 31-60, the sample will be 3 individuals.
    - If the population is more than 60 individuals, the sample will be 5% up to a maximum of 15 individuals.
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 individuals identified for the sample.

5. Provider staff will contact those individuals and arrange for interviews, reviews of records pertaining to those individuals, 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 individuals 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: Quality Improvement 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: Support Coordination 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 580-5-30, Intellectual Disabilities 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 individuals, 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 Chart (See List of Forms Table) based on the types of services provided. 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 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 individuals from this list as part of the representative sample or as additional individuals to have conversations about specific issues. However, this list is not exhaustive and/or mandatory. The selection of individuals for targeted interviews is tailored to 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 individuals, targeted interviews or review with individuals selected to be in the sample, the Certification Staff may ask questions of other individuals 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 individuals 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 individuals and no more than 30 individuals.
    - 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
        - Support Coordinator
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/Quality Improvement System monitoring, or facilitation of individualized goals and objectives identified in the Person-Centered Plan. 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. In addition to members of the organization undergoing the certification review attending the closing meeting, findings relating to Person Centered Plans may require attendance by the leadership of the Support Coordination Agency and the ADMH Support Coordination Liaison. Person-Centered Planning should be a collaborative effort that ensures a comprehensive plan, unique to the individual served, is developed. Opportunities ensuring Direct Support providers and Support Coordination Agencies work collaboratively to identify individualized support needs, must be evident during the certification review. The ADMH Support Coordination Liaison should be available to develop a

Technical Assistance Plan for the Support Coordination Agency that ensures a comprehensive Person-Centered Assessment is available for provider implementation.

**Please click the link below to access form:**

**FACTORS AND INDICATORS CHART FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Factors-and-Indicators-Chart.pdf

## A.6.2 PROVIDER TRAINING AND TECHNICAL ASSISTANCE

**Responsible Office:** Offices of Quality Assurance
**Reference:** ADMH Administrative Code 580-5-30-.11
**Revision Date:** March 1, 2026

**Statement:** The Office of Quality Assurance (QA) within the Alabama Department of Mental Health, Division of Developmental Disabilities (ADMH-DDD), is responsible for providing, coordinating, and/or overseeing mandated and elective training and technical assistance for contracted community provider organizations. These activities support provider compliance, promote continuous quality improvement, and ensure the health, safety, rights, and well-being of individuals receiving waiver services.

**Purpose/Intent:** This operational guideline establishes standardized expectations for provider training, professional development, and technical assistance. The intent is to:

- Identify areas in which providers may require support related to agency operations, regulatory compliance, and service delivery.
- Promote consistent, high-quality implementation of policies, procedures, and best practices.
- Support providers in maintaining systems that protect individual rights, reduce risk, and improve outcomes.
- Ensure statewide consistency in training and oversight activities.

**HCBS Waiver:** ID, LAH, CWP

**Definitions:**
Council on Quality and Leadership (CQL)
Human Rights Committees (HRCs)
Intellect Ability
Qualified Developmental Disabilities Professional (QDDP)
Quality Improvement System
Relias Learning Management System

**Procedure:**
1. TRAINING DELIVERY PLATFORM: Relias Learning Management System (LMS):
   a. Purpose and Scope
      - ADMH-DDD maintains Relias as the centralized electronic Learning Management System to ensure consistent, comprehension-based training for all contracted waiver service providers statewide.

- Relias serves as the primary platform for delivery, tracking, and documentation of mandated and elective training requirements.

b. Training Plan Management

- Mandated training modules housed in Relias are subject to modification as regulatory guidance, system priorities, or evidence-based practices evolve.
- Updates to training plans will be communicated to providers through official ADMH-DDD communications and reflected within the Relias system.
- Completion of mandated Relias training does not replace the provider's responsibility to ensure staff receive additional role-specific, individualized, and agency-specific training as required by ADMH-DDD operational guidelines, certification standards, and applicable administrative rules.
- Mandated training plans represent minimum requirements and are not exhaustive.

2. MANDATED TRAINING PLANS AND ELECTIVE COURSES

a. General Administrative Training Plan

- All employees of contracted community provider organizations must complete the General Administrative Training Plan upon hire and annually thereafter. Required topics include:
    - Overview of Intellectual and Developmental Disabilities (I/DD)
    - Home and Community-Based Services (HCBS) Overview
    - Rights of People Receiving Services
    - Philosophy of Self-Determination
    - Complaints and Grievances
    - Health Insurance Portability and Accountability Act (HIPAA)
    - Emergency Preparedness and Severe Weather Response
    - Infection Control, Medical Emergencies, and Signs and Symptoms of Illness
    - Abuse: Preventing, Recognizing, and Reporting
    - Incident Prevention and Management System (IPMS)
    - General Behavioral Principles
    - Person-Centered Thinking
- The mandated annual refresher includes, at minimum:
    - Rights of People Receiving Services
    - Complaints and Grievances
    - HCBS Overview
    - Abuse: Preventing, Recognizing, and Reporting
    - IPMS
    - HIPAA
    - Infection Control, Medical Emergencies, and Signs and Symptoms of Illness
- Relias includes functionality for providers to upload and maintain documentation for training and certifications completed outside of the system, including but not limited to:
    - CPR and First Aid
    - Tuberculosis Education
    - Management of Aggressive Behavior
    - Medication Assistant Certified (MAC) Credentials
    - Agency Policies and Procedures
- Providers are responsible for ensuring documentation is current and updated upon expiration or renewal. Accurate maintenance of training records in Relias serves as verification of compliance for internal monitoring and state-level reviews.

b. Direct Support Professional (DSP) Training Plan

- All Direct Support Professionals employed by contracted community providers must complete DSP training upon hire and annually thereafter. Required orientation topics include:
    - A Day in the Life of a Direct Support Professional
    - Overview of Different Types of Disabilities
    - Community Inclusion and Active Supports
    - Effective Direct Support Documentation
    - Cultural Competency and DisAbility Awareness
    - Identity-First Language
    - Methods of Communication
    - Professionalism in Direct Support Services
- The annual refresher includes:
    - Effective Direct Support Documentation
    - Community Inclusion and Active Supports
    - Cultural Competency and DisAbility Awareness
    - Methods of Communication

A list of additional elective modules is available in Relias. DSPs are strongly encouraged to complete these elective modules to enhance service quality and staff competency. c. Support Coordination Training Plan

- All Support Coordinators employed by contracted support coordination agencies must complete Support Coordination training upon hire and annually thereafter. Required topics include:
    - Person-Centered Planning
        - Expanded Conversation Guide
        - Comprehensive Assessment/PCAP
        - Current Daily Routine Schedule
        - Community Mapping and Natural Supports
        - HCBS Compliancy
        - Person-Centered Assessment and Planning Recertification Training
        - InLeads Guidance for Choice of HCBS
        - Dignity of Risk Balancing Choice and Risk
        - Risk Assessment and Mitigation Strategies
        - Budget Tool
    - Documentation
        - Informed Consent
        - Releases
        - Narratives
        - Progress Notes
    - Alabama Medicaid Agency
        - Chapter 106: Targeted Case Management
        - Case Management Training for Billing Medicaid
        - Chapter 107: Waiver Services
        - Chapter 3: Medicaid Eligibility Verification
    - Self-Directed Services
        - Self-Directed Services
        - SDS Spending Plan
    - Provider Manual

        - Chapter 1 - Eligibility, Enrollment and Disenrollment
        - Redetermination
        - Inventory for Client and Agency Planning (ICAP)
        - Waiver Services/Scope of Services
        - Request for Action Procedures
        - RFP & Transfers (interregional, other waivers)
        - Chapter 2 - Individual Rights (The Appeals Process)
        - Chapter 3 - Individual Support Planning and Implementation
        - Support Coordination (ID/LAH – Ch 4; CWP - Ch.3)
        - Behavioral Services
    - Electronic Medical Record Systems (ADIDIS)

d. Relias Training

- Relias provides access to a comprehensive library of training resources related to intellectual and developmental disabilities, supported employment, compliance, and healthcare.
- Providers are encouraged to utilize available courses beyond mandated requirements to strengthen organizational capacity and service quality.
- Elective ADMH-DDD developed and customized training content will also be housed in Relias.

e. Relias Access and Support

- Providers requiring assistance with Relias access or functionality should contact the Quality Assurance Training and Systems Specialist for support.

3. QUALIFIED DEVELOPMENTAL DISABILITIES PROFESSIONAL (QDDP) CERTIFICATION

a. Certification Overview

- ADMH-DDD maintains a standardized QDDP certification process to ensure professionals possess the knowledge, skills, and ethical commitment necessary to support individuals with developmental disabilities.

• Certification requirements include:

• Verification of qualifications and experience. A QDDP Should:
    - Have at least one (1) year of experience working directly with persons with Intellectual Disability (ID) or other developmental disabilities; and
    - Be classified as one of the following:
        - A Doctor of Medicine or osteopathy
        - A registered nurse
        - An individual who holds at least a bachelor's degree in a human services field
- Execution of a professional attestation.
- Completion of required in-person and virtual training.
- Completion of Human Rights Committee (HRC) training.
- Annual refresher training.
- Maintenance of current employment status on the QDDP Registry.

b. Qualifications Verification

- Applicants must submit:
    - A completed application.
    - Proof of a bachelor's degree in the field of human services through an official transcript.
    - Documentation of required experience through a resume and professional reference(s).
- Primary source verification will be required by ADMH-DDD.
- Applicants must sign an attestation agreeing to professional, ethical, and practice standards prior to training approval.

c. QDDP Onboarding and Training Requirements

- In-Person Training (Regional):
  - Introduction: QDDP Role, Values, Ethics, & Expectations
  - Overview of Alabama Waivers
  - Overview of State Systems Utilized
  - Behavioral Supports Overview
  - PCP Process and QDDP Role in Implementation
  - Culture/Environment of Support, Communication, Leadership (supervision)
- Virtual Training (Within 30 Days):
  - CQL Modules
    - Overview of QDDP
    - Rights: Informed Consent, Due Process, Guardianship
    - Health/Medical Safety
    - IPMS
    - Assessments
  - MAC I (The QDDP applicant will need to upload their MAC I Certificate into the appropriate Requirements Tracker in Relias.
  - PCP/ Support Coordination Training for Direct Support Providers
  - Person-Centered Thinking (Intellectability)
  - Fatal Five (Intellectability)
- Additional In-Person Requirement (Within 90 Days):
  - Human Rights Committee (HRC) training (Certificate must be uploaded into Relias requirement tracker.)

d. Certification Issuance and Validity

- Upon verification of all requirements, the QA Training and Systems Analyst will issue a QDDP certificate valid for one (1) year from the certification date.

e. Annual Refresher

- QDDPs must complete annual refresher training virtually in Relias to maintain certification. A grace period of 30 days prior to expiration and 60 days following expiration applies.

f. QDDP Registry

- ADMH-DDD maintains a registry of all certified QDDPs. QDDPs are responsible for:
  - Maintaining active certification status
  - Completing required annual training
  - Reporting all employing agencies and changes in employment.

4. TECHNICAL ASSISTANCE – QUALITY ASSURANCE

a. Quality Improvement Systems

- QA staff provide training and technical assistance related to Quality Improvement Systems required under Alabama Administrative Code 580-5-30.
- Providers must maintain internal monitoring systems that:
  - Measure compliance with values and requirements
  - Support continuous learning
  - Utilize data to inform corrective actions and system enhancements.

b. Incident Prevention and Management System (IPMS)

- The Office of Quality Assurance oversees the Division of Developmental Disabilities' Incident Prevention and Management System (IPMS), which provides guidance for community providers to ensure critical incident identification, reporting, investigation, and analysis procedures are consistently implemented to protect waiver participants from harm. QA staff in the regional

community services offices (Incident Managers) provide ongoing incident management by reviewing critical incidents, ensuring proper notifications are made, and making recommendations to community providers to improve service delivery.

c. Fatal Five

- Training modules developed by IntellectAbility on the Fatal Five are available in Relias.
- The Fatal Five includes the following:
    - Aspiration
    - Bowel Obstruction
    - GERD
    - Seizures
    - Infection/Sepsis

d. Human Rights Committees (HRCs)

- ADMH-DDD provides quarterly trainings on the topic of Human Rights Committees (HRCs).
- There are two types of HRC trainings offered.
    - One class is designed to instruct members of HRCs, chairpersons, and agencies who participate in and/or facilitate HRCs at their organizations on proper structure, policies, and rights/due process facilitation of these important committees. The second type is designed for self-advocates, families, and other stakeholders, providing an overview of how HRCs can be utilized to exercise their rights and provide a framework of HRC structure if participants are interested in joining HRCs in their communities.
- The goals of the HRC trainings are to:
    - Understand the expanded focus on rights in the HCBS Settings Rule.
    - Understand the foundational principles of HRC operations.
    - Learn effective ways to apply these principles in individual rights protections and promotions. understand the committee's role in helping to prevent abuse, neglect, and exploitation.
    - Identify/create resource networks of assistance to help solve problems in the future.
    - Share information across agencies.

e. HCBS Community Resource

- ADMH-DDD hosts a website (https://hcbscommunity.alabama.gov) where community providers can access resources and request feedback on the ongoing implementation of the HCBS Setting Rule.
- The site includes sample policies and procedures, a calendar of events, success stories, and the ability to ask questions about HCBS topics that will be answered by QA staff..

5. CONTINUOUS QUALITY IMPROVEMENT

a. Overview

- ADMH-DDD is committed to continuous quality improvement. QA staff conduct data collection, analysis, on-site visits, and interviews to assess provider performance and satisfaction. Findings inform training priorities, technical assistance, and system-wide improvement initiatives. Providers may request individualized technical assistance through their regional Quality Assurance Specialist. For additional training offerings, please see the Procedural Guidelines for *Personal Outcome Measures and Person-Centered Thinking*.

## A.6.3 DEVELOPMENTAL DISABILITIES CERTIFICATION POLICY AND PROCEDURE REQUIREMENTS

### A.6.3.a ADMH-DDD Support Homes (Non-Waiver)

**Responsible Office:** Offices of Certification
**Reference:** Alabama Administrative Code 580-1-4, 580-2-9,580-2-20, 580-3-25, 580-3-26, 580-5-30
**Effective:** January 9, 2025

**Statement:** The organization will comply with requirements of DMH Standards and Community Standards for Services for Persons with Intellectual Disabilities except for state and federal guidelines relating to Home and Community Bases Waiver Services.
Purpose/Intent: The purpose of this Operational Policy is to provide certification policy and procedure requirements for agencies delivering services and supports to individuals that do not meet HCBS requirements.

**HBCS Waiver:** DDD Non-Waiver HCBS Providers

**Key Terms:**
Non-Waiver HCBS Provider
Non-Waiver HCBS Setting
2014 HCBS Settings Rule
**Procedures:** Procedures: All Intellectual Disabilities services that are not required by the HCBS Waiver will be provided in accordance with the DMH Standards and Community Standards for Services for Persons with Intellectual Disabilities. The certification review process will be conducted in accordance with OG A.6.1. Appropriate certifications will be maintained in accordance with applicable standards. Community service providers will maintain records on all individuals receiving services and/or supports in accordance with DMH Standards, applicable state and federal programs and laws such as Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.
Contracted non-waiver HCBS providers must have written policies and procedures that are effectively implemented in such a way as to assure the health, safety, and individual security of individuals receiving services and supports.
The organization's written policies and procedures will be approved, reviewed, and updated by the governing board, as appropriate but at least annually and available to all employees and individuals receiving services and supports. All employees will be trained on the policies and procedures including what constitutes effective and appropriate implementation of each policy and procedure.
Policies and procedures, as well as evidence of implementation, will address, at a minimum, the following areas:

a. Protection from abuse, neglect, mistreatment, and exploitation.
b. Best possible health.
c. Safe environments.
d. Staff resources and supports
e. Positive services and supports.
f. Continuity and personal security.
    - Policies and procedures to address the overall requirements of the governing body, business, and administrative supports of the individuals served.
    - Policies and procedures to address fiscal practices in managing individuals' funds and

other personal resources.

- Policies and procedures to address business practices, which includes maintaining a record of information promoting continuity of services and security of individual information, in support of individuals served.

g. Quality improvement system.

All policies and procedures will meet the requirements as outlined in the Department of Developmental
Disabilities' Operational Policy.

## A.6.3.b Promotion and Protection of Individual Rights

**Responsible Office:** Office of Certifications
**Reference:** Administrative Code 580-5-30, 580-3-26, Home and Community Based Services Settings (HCBS) Rule
**Effective:** October 1, 2020
**Revised:** April 1, 2023

**Statement:** This process is to guide certification staff in assessing community provider compliance with providing quality supports in the area of individual rights.
Purpose/Intent: To provide a process that ensures the provider practices sound management providing quality services to individuals.

**HCBS Waiver:** ID/LAH

**Key Terms:**
Home and Community Based Services (HCBS) Settings Rule

**Procedures:**

1. The Organization Implements Policies and Procedures That Clearly Define Its Commitment to and Addresses the Promotion and Protection of Individual Rights of Individuals.
   a. The policy lists rights afforded all citizens as indicated by the (US) Constitution, laws of the country, and the State of Alabama.
   b. The policies and procedures describe the organization's due process.
   c. The policies and procedures for due process include individual rights review and documentation in the event of a proposed restriction of an individual's rights.
   d. The organization refrains from having standing policies and procedures that restrict an individual's rights without due process.
   e. The organization develops policies and procedures that address all requirements of the HCBS settings rule that includes training of individuals supported and all staff.
2. The Organization Informs Individuals of Their Rights.
   a. The organization documents verification that it provides to individuals and their legally authorized representatives an oral and written summary of their rights/responsibilities and how to exercise them upon admission and annually thereafter.

b. The information (in line 1 above) is provided in a format that is in language and style that is easily understood by the individual.

3. The Organization Supports Individuals to Exercise Their Rights and Responsibilities.
   a. The organization assesses each individual's ability to understand and exercise his or her rights on an ongoing basis but at least annually
   b. The rights assessment addresses individual's civil and legal rights and individual freedoms. The assessment includes but is not limited to the ability to do the following
      - Exercise freedom of movement with physical environments, which includes living units with lockable entrance doors, with individuals served and only appropriate staff who have keys. This will be documented in the person- centered plan (PCP). If there is more than one bedroom, each bedroom should be considered a unit and the "tenant" should have a key to their lockable door. This rule applies to Home and Community-Based Services (HCBS) and settings
      - Have a lease, residency agreement or other form of written agreement in place that provides protections, and addresses eviction processes and appeals comparable to those provided under the state's landlord tenant law.
      - Manage money
      - Send and receive mail including a private place to read and open mail.
      - Privacy to make and receive phone calls and use other means of communication.
      - Have visitors of their choosing at any time. Any restriction of visitors or visitations of the individual's choice must be based on individualized, assessed that is documented in the person-centered plan along with what efforts that will be taken to try to reduce or move the restricted access as soon as may be feasible. This rule applies to Home and Community-Based Services (HCBS) and settings.
      - Access individual possessions.
      - Vote and otherwise participate in the political process.
      - Make choices about religious affiliation and participation.
      - Interact socially with members of either gender.
      - Privacy including a choice of private bedroom or choice of a roommate with furnishings positioned to maximize privacy.
      - Access to food at any time
      - Freedom and support to control schedules and activities. This rule applies to Home and Community-Based Services (HCBS) and settings.
   c. The rights assessment addresses the need for and scope of advocacy, guardianship and alternatives for each person.
   d. Rights assessment results, including supports needed to protect and promote the individual's rights, are documented in the individual's record.
   e. The organization provides assistance to the person in areas identified as important by the individual and that individual's support team.
   f. The organization provides education regarding voter registration and the voting process to anyone age 18 or over that expresses an interest.
   g. The organization assists individuals with voting as needed. (Note: this is not applicable for individuals deemed incompetent due to Alabama voting laws.)

h. The organization provides individualized supports/services that are free from discrimination (race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances.)
i. The organization obtains written, informed consent (from the individual) prior to any intrusive medical or behavioral intervention, and prior to participation in research.
j. The consent contains information regarding procedures to be followed, expected benefits of participation, and the potential discomforts and/or risks.
k. The consent information is presented in a non-threatening environment and explained in a language that the individual can understand, and the individual is also informed that they may withhold or withdraw consent at any time.
l. The organization shares information about individuals only with their written, informed consent or that of their legally authorized representative.

4. Decision-Making Supports are Provided to Individuals as Needed.
   a. The organization refrains from presuming incompetence or denying individuals' rights to manage financial or personal affairs or exercise other rights solely by reason of his/her having received support services, unless legally determined otherwise.
   b. Unless a legal determination of incompetence to participate in one or all of the following activities has been made, every individual is free to access courts, attorneys and administrative procedures, execute instruments, dispose of property, marry and divorce or participate in activities requiring legal representation, make choices regarding services and supports and who provides then without fear of reprisal, interference, or coercion. The individual is informed of all setting options including non-disability specific settings and an option for a private room in their setting. This information is documented in the person-centered plan.
   c. Individuals receive only the level of support needed to make their own decisions. Supports include assisting individuals to advocate for themselves.
   d. Each individual has a written plan to obtain advocacy, guardianship and alternatives to guardianship if those supports are needed. Support Coordination and Provider Organizations shall not serve in a guardianship capacity to those individuals that they directly or indirectly support.
5. Staff are Trained to Recognize and Honor Individual's Rights.
   a. Staff are trained to recognize and demonstrate respect for individuals' rights including how individuals choose to exercise their rights.
   b. Staff that complete rights assessments are trained to:
      - Understand and support individuals' preferences in regard to rights,
      - To identify goals related to exercising their rights and to support attainment of those goals
   c. Staff are trained in due process procedures.
   d. Staff are trained in any procedures for placing a limitation or restriction on an individual's rights.
6. The Organization Upholds Due Process Requirements.
   a. The organization's due process is defined as providing individuals supported, and their legally authorized representatives, with a fair process requiring at least an opportunity to present objections to the proposed action being contemplated.
   b. Due process, including review by a Human Rights Committee, is implemented when it is proposed that an individual's rights be restricted for any reason.

c. A Human Rights Committee (HRC) reviews any restriction of an individual's rights including an assessment indicating the need for the restriction periodically, but at least annually, during the period in which the restriction is imposed, and documents such.
d. All restrictions are included in the individual's person-centered plan. When any restrictions are being proposed for an individual, the individual is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.
e. Individuals are provided adequate training in due process procedures including:
    - Any procedures for placing a limitation or restriction on an individual's rights'
    - Training that supports the removal of a rights restriction.
f. The continued need for the restriction is reviewed at least quarterly by the QDDP or more often at the request of the individual. All restrictions are included in the person- centered plan.

7. The Organization Has Access to a Working and Effective Human Rights Committee.
    a. The organization utilizes a working and effective HRC that complies with the provisions of 580-3-26.
    b. The HRC reviews policies, procedures and practices that have the potential for rights restrictions without individualized assessment.
    c. The HRC reviews the frequencies and reasons surrounding the use of restraint for medical and/or behavior purposes.
    d. The HRC meets at least quarterly.
    e. The HRC is composed of a majority of individuals that are not employed by the program, and consisting of representatives from each of the following groups:
        - Current and/or former service users,
        - Family members of service users,
        - Representatives of community support and advocacy organizations,
        - Local official,
        - Citizens at large,
        - Performance Improvement/Quality Enhancement staff (ex-officio)
    f. The HRC does the following:
        - Makes recommendations to promote individuals' rights,
        - Proactively promotes and protects individuals' rights,
        - Reviews reports of substantiated allegations of abuse, neglect, mistreatment and exploitation,
        - Reviews other data that reveals practices with respect to human, civil and legal rights,
        - Reviews research projects involving human participation to ensure the protection of the individuals who are involved,
        - Assists on the review of rights related policies and procedures,
        - Promotes rights related education and training programs,
        - Reviews rights restrictions,
        - Assists in monitoring activities; advise the program administrator on consumer rights-related grievances, Reviews rights related issues in behavioral plans.

8. Services are Provided In a Safe and Humane Environment.
    a. Adequate furniture, supplies and equipment are available as needed to support needs and outcomes of individuals served.

b. Furniture, supplies and equipment are in good repair and operating effectively.
c. Supplies, equipment or devices (such as adaptive, therapeutic, corrective, prosthetic, orthotic and mobility devices) that are for individual use are in good repair for the person who requires their use.
d. Food is available that is nutritious and is available in quantity and variety to meet individual's dietary needs and preferences and will be available at any time without restriction. Any restrictions to access to food must be based on individualized assessed need that is documented in the person-centered plan along with what efforts will be taken to try to reduce or remove the restricted access as soon as may be feasible. This rule applies to Home and Community-Based Services (HCBS) and settings.
e. The organization maintains current certification and licenses for operations and complies with all posting and notification requirements of the local, state and federal offices.

## A.6.3.c Dignity and Respect

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30 Effective: October 1, 2020
**Revised**: March 26, 2021

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of dignity and respect.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.

**HCBS Waiver:** ID/LAH

**Procedures:**
1. Individuals Are Treated as Individuals First
   a. The organization's policies and procedures reflect and reinforce.
   - Courteous practices towards individuals,
   - The avoidance of labels to describe individuals based on physical characteristics or disabilities,
   - The practice of addressing individuals by their preferred names,
   - Privacy in an individual's bedroom with furnishings selected and arranged by the individual, and
   - Ensuring the setting is physically accessible to the individual.

   b. The organization provides training to staff and volunteers on policies regarding dignity and respect
   c. The organization's identifying information (name, letterhead, etc.) promotes a positive image of individuals, services, and supports.
2. The Organization Respects Individuals' Concerns and Responds Accordingly
   a. The organization provides individuals supported and their legally authorized representatives with the information regarding filing complaints and grievances.
   b. The complaint/grievance procedures include the name and telephone numbers of the local contact.

c. The designated local contact has the knowledge to inform individuals, families, and legally authorized representatives of the means of filing complaints and grievances and of accessing advocates, ombudsmen, or rights protection within or outside the organization.
d. The grievance procedure information is available in frequently used areas, particularly where individuals receive services.
e. Notices include the toll-free numbers for the DMH Advocacy Office, the Alabama Disabilities Advocacy Program (ADAP), a federal protection and advocacy system, and the local Department of Human Resources office.
f. The organization provides access to individuals and advocates, including a DMH internal advocate and the grievance process, without reprisal.
g. Responses to grievances and complaints are provided in a timely manner per the agency's procedures.
h. Responses are made in a manner and format that is relevant and understandable.
i. The organization implements a system to periodically, but at least annually, review all grievances and complaints.

3. Individuals Have Privacy
   a. The organization provides space for individuals to:
      - speak or interact with others in private
      - to open and read mail or other materials
   b. The organization affords every individual the right to privacy.
   c. Support staff demonstrate respect for individuals' privacy when:
      - providing supports for bathing, dressing and personal hygiene in a private manner, and
      - when entering personal spaces.
4. Supports and Services Enhance Dignity and Respect.
   a. Practices enhance dignity and respect while recognizing individual choices and preferences.
   b. Individuals receive needed supports to:
   - ensure healthy hygiene and personal cleanliness
   - choose clothing that is clean, fashionable, and fits
   - decorate their personal spaces based on choice while maintaining environments that are safe and sanitary.
   c. Transportation and other supports are provided so individuals can access community services in a manner similar to others.
   d. The organization has policies related to privacy that address consent and the use of video surveillance and other electronic recording devices such as cell phones, cameras, video recorders, etc.
5. Individuals Have Meaningful Work and Activity Choices.
   a. Personal assessments:
      - identify preferred work and activities,
      - identify practices to help individuals to make choices based on preferences and assist individuals to achieve goals.
   b. Choices of activities and work encourage and promote age-appropriateness and a positive self-image. Options consider the individual's cultural background and preferences.

c. The organization provides individual assessments that identify preferred work activities, including assessing interest in competitive integrated employment, identifying practices to help individuals make choices based on preferences, and assisting individuals to achieve goals.
d. There are options for individuals that are age and culturally appropriate, normative, and promote a positive self-image and are identified preferences documented in the Person- Centered Plan (PCP) with appropriate goals and objectives.
e. The organization facilitates opportunities for competitive integrated employment and supports when employment is the choice of the individual and prescribed in the individual's PCP.

## A.6.3.d Natural Support Networks

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30
**Effective:** October 1, 2020
**Revised:** March 26, 2021

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of natural support networks.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.

**HCBS Waiver:** ID/LAH

**Key Terms:**
Natural Supports

**Procedures:**
1. Policies and Procedures Facilitate Continuity of Natural Support Systems
   a. The organization will have policies and procedures that define natural supports and acknowledge the importance of natural supports in promoting identity, personal security, and continuity for individuals served by the organization.
   b. Natural Supports will be defined as family, friends, and community resources such as local organizations, clubs, places of worship, schools, or other places where new and existing relationships can be built and facilitated outside of the organization.
   c. Organizational policies and practices will reflect how to facilitate continuity in existing relationships and supports and or building new relationships using community resources.
   d. Organizational policies and practices will reflect how organization will assist individuals in making and maintaining their natural supports.
   e. Organizational policies and practices will reflect how organizations will assist individuals to contact their natural supports.
   f. Organization's facilitation of natural supports will include promoting visits to the homes of families and friends to individual's setting. (NA for Day and Non-Congregate Services)
   g. Organization's facilitation of natural supports will include promoting visits of families and friends to individual's setting. (NA for Day and Non- Congregate Services)

h. Organization's staff will consider individual's health, safety, and well-being while planning visits with family and friends. (NA for Day and Non-Congregate Services)
i. Training will be provided to staff and volunteers to develop and/or improve skills to support the individual's communication and contact with natural supports, especially families and friends.

2. The Organization Recognizes Emerging Support Networks
    a. The organization will have a mechanism to identify and support existing and potential or emerging natural supports for each individual.
    b. The organization will address ways to connect individuals to natural supports including addressing and overcoming barriers.
    c. The organization will have strategies to build the capacity for natural supports based on individual's choices and preferences.
    d. The organization will pursue the use of family members or close personal friends to assist individuals with decision-making.
3. Communication Occurs Among Individuals, Their Support Staff and Their Families
    a. The organization will have internal communication systems for individuals, their support staff, and families that:
        - provides choices about extent and frequency of contact with their natural support networks.
        - ensures inquiries from those in individuals' natural support systems are responded to in a natural and timely manner.
        - has a mechanism for legally authorized representatives, and others identified by individuals to receive information and be notified promptly and compassionately of incidents involving the individual.
    b. The organization will maintain written contact information including records of names, addresses, and phone numbers of family and friends who are important to individuals.
    c. The organization will include a variety of methods for helping individuals stay connected to natural supports.
4. The Organization Facilitates Each Individual's Desire for Natural Supports
    a. The organization will document individuals' satisfaction with the amount of contact with their natural support system.
    b. The organization will document individuals' involvement with their natural support systems.
    c. The organization will clearly identify expectations related to visits or other interactions with natural supports based on the desires of the individual being supported.
    d. The organization will provide private space for visits and interactions with members the individual's natural support network.

## A.6.3.e Protection from Abuse, Neglect, Mistreatment, and Exploitation

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30, Community Incident Prevention and Management System (IPMS)
**Effective:** October 1, 2020
**Revised:** March 26, 2021

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of protection from abuse, neglect, mistreatment, and exploitation.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.

**HCBS Waiver:** ID/LAH

**Procedures:**

1. The Organization Implements Policies and Procedures That Define, Prohibit, and Prevent Abuse, Neglect, Mistreatment, and Exploitation.
    a. The organization will implement a Community Incident Prevention and Management System (IPMS) as required by the Department of Mental Health (DMH), Division of Developmental Disabilities (DDD) to protect individuals served from harm and improve the organization's responsiveness to incidents for purposes of prevention of harm and risk management.
    b. The organization will notify the DDD of all reportable incidents and take action in accordance with the Community IPMS.
    c. The organization will develop policies and procedures that are consistent and comply with requirements of the Community IPMS. The policies and procedures will identify, define, prohibit, and prevent abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation.
    d. Definitions of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation will be comprehensive, specific, and consistent with Community IPMS definitions.
2. The Organization Promotes Freedom from Abuse, Neglect, Mistreatment, and Exploitation.
    a. The organization will provide individuals with understandable information about their right to be free from abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation.
    b. The organization will have a complaint process that is understandable and easy to use.
    c. Individuals will be supported to report allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation.
    d. Allegations reported by employees or others, including individuals supported by the organization, are managed consistently and in the same manner.
    e. The organization will ensure individuals who cause injury or harm to themselves, or others receive supports to replace those behaviors consistent with the Alabama Department of Mental Health, Division of Developmental Disabilities Behavioral Services Procedural Guidelines (DDD-PBS-01-05).
    f. When there are allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation or other reportable incidents, the organization will take immediate action and ensure individuals are protected.
    g. The organization will assist individuals who have been subjected to abuse, neglect, mistreatment, including the unauthorized use of restraints, or exploitation to access supports to address the effects of the abuse even if:
        - The abuse occurred before they entered into the organization's system of services or
        - The perpetrator is another individual who receives supports.

h. Incidents resulting in injury where both the perpetrator and the victim receive services will be investigated or clinically reviewed to determine:
    - if the occurrence of such an incident may have been the result of neglect and/or
    - if additional supports are needed for the individuals involved.

3. The Organization Follows Reporting Requirements for Allegations or Suspected Incidents of Physical, Verbal, Sexual or Psychological Abuse, Mistreatment, Neglect, or Exploitation Regardless of Age.
    a. The organization will follow minimum protocols as specified in DMH/DD Community IPMS guidelines for reporting, investigation, and follow-up processes.
    b. The organization will have procedures for reporting incidents and injuries in accordance with all applicable laws and DMH/DD requirements, including the Community IPMS.
    c. The organization will notify an individual's responsible relative/guardian immediately in the event of a medical emergency or death.
4. The Organization Ensures Objective, Prompt and Thorough Investigations of Each Allegation of Abuse, Neglect, Mistreatment, and Exploitation, and of Each Injury, Particularly Injuries of Unknown Origin.
    a. The organization will provide documentation that it conducts investigations in accordance with timelines established by the Community IPMS guidelines.
    b. The organization will follow the recommendations for incident and investigation reports in the Community IPMS.
5. The Organization Ensures Thorough, Appropriate and Prompt Responses to Substantiated Cases of Abuse, Neglect, Mistreatment, and Exploitation and Associated Issues Identified in the Investigation.
    a. The organization will document the internal investigation/review and follow up action of all allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, or exploitation.
    b. The organization will ensure investigation outcomes and recommended actions are implemented in accordance with the Community IPMS Guidelines.
    c. The organization will ensure an initial and comprehensive mortality review is completed and available.
6. Support Staff Knows How to Prevent, Detect, and Report Allegations of Abuse, Neglect, Mistreatment, and Exploitation.
    a. The organization will ensure all staff receive orientation on what constitutes abuse, neglect, mistreatment, and exploitation. This includes prevention, detection and reporting requirements as specified in internal agency procedures, Community IPMS Guidelines, and any other applicable federal or state requirements.
    b. The organization will ensure staff with specific responsibilities related to reporting, investigating, or documenting requirements contained in the Community IPMS receive appropriate training in their areas of responsibility and in specific procedures as well.
    c. The organization's policy and practice will demonstrate continuous efforts to ensure freedom from abuse, exploitation, neglect, or mistreatment are demonstrated. Efforts will include ongoing training in prevention, detection, and reporting and occur frequently enough, but at least annually, to support both individual and organizational outcomes.
    d. The organization will provide training on specific supports, services, policies and procedures, or other corrective action deemed appropriate, immediately when support staff competency is

identified as a (potential) causal factor for substantiated incidents of abuse, exploitation, neglect, or mistreatment, including the unauthorized use of restraints, and exploitation.

e. The organization will evaluate potential underreporting and screening of allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation and provides additional training as needed.

f. The organization will develop and implement policies and procedures consistent with Section VIII of the Community IPMS and their internal quality improvement system process that reports incident data and identifies trends, patterns or isolated incidents that may be indicative of abuse, neglect, mistreatment, or exploitation.

## A.6.3.f Best Possible Health

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30, Alabama Board of Nursing Administrative Code 610-X-7, MAS Nurse Manual
**Effective:** October 1, 2020
**Revised:** March 26, 2021

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of Best Possible Health.

**Purpose/Intent:** To provide a process to ensure the provider practices sound management providing quality services to individuals.

**HCBS Waivers:** ID/LAH

**Procedures:**

1. Individuals Have Supports to Manage Their Own Healthcare
   a. The organization's policies and procedures must ensure:
      - Individuals are given the opportunity to choose health care providers as desired.
      - Individuals are supported to make their own health care appointments and choices regarding their medical care as needed.
      - Individuals are provided understandable information about their current and past health conditions, their medications, and their treatments, including the purpose, intended outcomes, side effects or other risks and alternatives.
      - Individuals have access to all their health care records.
      - An Individual's preferences and ability to self-administer medications and treatments are assessed at least annually in compliance with the Nurse Delegation Program.
      - Supports are available to assist individuals with medications and treatments if necessary.
      - Individuals are supported to become knowledgeable about how to access emergency medical care and to access it as needed.
2. Individuals Access Quality Healthcare

a. Within three hundred sixty-five (365) days prior to initial admission to a community-based program or service, each individual has a physical examination conducted by a licensed physician or certified nurse practitioner.
b. Individual's medical status and needs are reviewed annually within ninety (90) days prior to or at the same time as the annual Person-Centered Plan meeting. This is evidenced by a report from a physical examination by a licensed physician or certified registered nurse practitioner conducted within the last year.
c. Individuals are assisted in obtaining preventive and routine health services including physical examinations, immunizations, and screenings consistent with their age and risk factors as recommended by their personal physician. Preventive health care strategies/interventions contained in the Person-Centered Plan, based on the individual's current health status and age, are implemented, and will be carried out according to the Centers for Disease Control recommendations regarding preventive/screening practices. Emphasis will be placed on age-specific screening tests.
d. Each individual newly admitted to a program has a TB skin test with documented results, unless there is written evidence that such testing was previously done or there is a medical contraindication for the procedure. An annual TB skin test is conducted as medically indicated. If the skin test yields a questionable result, the organization follows up with a physician for necessary screenings and/or treatments.
e. Individuals who require supports for mobility are provided with assistance and supports to prevent skin breakdown. Individuals have therapeutic and adaptive equipment that fits them and is in good repair.

3. Health Needs Are Addressed in A Timely Manner
   a. An individual who develops a medical problem, either an emergency or acute health care change, is assessed in a timely manner. Treatment/care and monitoring of the individual's condition is provided in accordance with good standards of nursing or medical care to resolve the problem effectively.
   b. The organization has systems in place that ensure ongoing communication between individual's health care support staff and outside health care staff promotes continuity of care.
   c. Each individual's Person-Centered Plan indicates his/her health needs and outlines specific actions and time frames to address these needs. Actions taken are documented. Health needs include, but are not limited to, physical, neurological, dental, nutrition, vision, hearing, speech/language, PT/OT,0, and psychiatric services.
   d. When available, individual's records document hospital summaries that include the discharge diagnosis, current health status, necessary follow-up instructions and any restrictions or limitations of recent hospitalizations. Organizations shall document efforts to obtain hospital summaries.
   e. Individual's records document acute health changes to provide a clear picture of the course of the illness or injury, the treatment provided, and the individual's current status from the time of identification through resolution.
   f. As part of the Person-Centered Plan, health care plans and supports are modified in a timely manner based upon acute health care changes.
4. Staff Immediately Recognize and Respond to Medical Emergencies

a. Direct support staff (non-licensed medical personnel) receives training to recognize and respond to individuals experiencing medical emergencies.
b. Provide medical equipment ordered by a physician to respond in a potential emergency for pre-existing (known) conditions, ensuring it is well maintained, clean and functional.
c. Provide medication ordered by a physician to respond in a potential emergency in the appropriate dose, quantity, and form.
d. Ensure first aid kits are available and appropriately stocked for the provision of initial care for an illness or injury.

5. Individuals Receive Medications and Treatments Safely and Effectively
   a. Organizations implement policies and procedures approved by their Boards of Directors requiring full compliance with the Alabama Board of Nursing's Regulation 610-X-7-.06, Alabama Department of Mental Health Residential Community Programs.
   b. The unit dose or individual prescription system is used for all prescription drugs.
   c. All medications are labeled and stored in accordance with criteria herein.
      - Medications are stored under lock and key.
      - ii. All narcotic medications, Schedules 2, 3, 4, and 5 are stored under double lock and key.
      - Medications are stored separately from non-medical items.
      - Medications are stored under proper conditions of temperature, light, humidity, sanitation, and ventilation.
      - Internal and external medications are clearly labeled as such and stored separately from each other.
      - The organization is able to document ongoing accountability for all prescription medication through an inventory process.
   d. Medications, both prescription and non-prescription, are administered and recorded according to valid orders and in compliance with the Alabama Board of Nursing's Regulation 610-X-7-.06, Alabama Department of Mental Health Residential Community Programs, and the Nurse Delegation Program.
   e. Prescription medications are used only by the individual for whom they are prescribed. Over the counter (OTC) medications are issued to or retrieved by an individual from his/her own supply in accordance with the Nurse Delegation Program.
   f. Each prescription medication which is identifiable up to the point of administration. Identifiable means that it is clearly labeled with the name of the individual, name of the medication, and the specific dosage. Prescription medication labels state the expiration date. Names of medications on labels match the Medication Administration Record.
   g. All medication errors and reactions to medications are recorded and reported in accordance with written policy, the Community Incident Prevention and Management System (IPMS) Guidelines, and the Nurse Delegation Program.
   h. Documentation of corrective action taken regarding medication errors, is maintained by the agency for five years.
   i. Discontinued and outdated medications are promptly disposed of in a safe manner. Disposal can be implemented only by a nurse, pharmacist, or physician and must be witnessed and documented in accordance with policy.
   j. Each individual who receives medication receives medical supervision by the prescribing physician, to include regular evaluation of the individual's response to the medication.

k. Individuals receiving psychotropic medication are seen and evaluated by a licensed physician, preferably a psychiatrist, at intervals not to exceed a six (6) month period. Reviews of the use of psychotropic medications for each individual are conducted by a licensed physician to ensure the drug is effective, is being given at the lowest possible dosage and is consistent with appropriate standards of care.
    - Factors/criteria to be taken into account for consideration of psychotropic medication reduction(s), are identified, assessed, and documented. Potential reduction of the psychotropic medication is discussed with the physician and documented and may only be ordered by a physician.
    - Blood level examinations for individuals receiving anti-convulsant and psychotropic drugs are repeated as often as clinically indicated for potential toxic side effects and to ensure levels are within therapeutic range. Results of most recent blood level examinations are maintained in any organization in which medications are administered. In the event a copy of blood work cannot be obtained, a letter from the physician stating the individual is in his usual state of health is adequate.

    l. Individuals may administer their own medication when all the following have been established and documented in accordance with regulations of the Nurse Delegation Program:
        - The individual has been provided with information regarding the purpose, dosage, time, and possible side effects of the medication and has verbalized/effectively communicated understanding.
        - The individual has been instructed regarding what to do and who to call if a dose is missed, if extra medication is taken, or if adverse reaction is experienced and has verbalized/effectively communicated this understanding.
        - The individual has been educated in the maintenance of his/her own medication history and in the recording of information needed by the physician to determine medication and dosage effectiveness. The individual has verbalized/effectively communicated understanding and can perform a competent return demonstration of self-administration of medication.

m. Medication utilized by an individual for self-administration is not locked away from him/her. However, it is secured out of reach of other individuals who have not been determined to be capable of self-administering his/her own medication.

n. Self-medication desire and safety is discussed during the individual's annual Person- Centered Plan meeting and any concerns noted in this area are addressed and documented.

o. The organization supports self-administration of medication through periodic monitoring of administration and documentation of continued proficiency by the individual.

p. For residential and day services, there is a Medication Assistance Supervising (MAS) trained registered nurse or licensed practical nurse as a full-time or part-time employee or consultant to the provider responsible for supervision of delegation of medication assistance to the unlicensed personnel.

q. In residential services, access to an on-call MAS nurse must be available twenty-four (24) hours a day, seven (7) days a week.

## A.6.3.g Safe Environments

**Responsible Office**: Offices of Certification
**Reference:** Administrative Code 580-5-30, Administrative Code 580-3-22
**Effective:** October 1, 2020
**Revised:** March 26, 2021

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of safe environments.

**Purpose/Intent:** To provide a process to ensure the provider practices sound management providing quality services to individuals.
**HCBS Waivers:** ID/LAH

**Procedures:**
All environments must be designed and maintained to be accessible, safe, and sanitary for individuals.

1. The Organization Provides Individualized Safety Supports.
    a. Safety supports within an environment are available to the extent they are needed, based on a required functional assessment.
    b. Assessment includes, but is not limited to, safety in the kitchen, ability to adjust hot water, ability to evacuate in the event of fire or severe weather, call for help, use cleaning supplies, and other safety concerns specific to the individual or the particular living environment.
    c. Assessment results are documented.
2. The Physical Environment Promotes Individual's Health, Safety, and Independence.
    a. Kitchen areas, electrical appliances, and outlets are free of any unnecessary hazards.
    b. The organization assures the building temperature is comfortable for individuals served, according to weather conditions (a normal comfort range in most instances is defined as not going below a temperature of 70-F or exceeding a temperature of 80-F).
    c. Environments are clean, pest free, and adequately maintained to ensure basic safety.
3. The Organization has Individualized Emergency Plans.
    a. Organizations have emergency plans to deal with a variety of situations and accommodate the specific needs of each individual.
    b. Appropriate visual signs and alarms are in place for individuals who need them.
    c. Quarterly severe weather drills and monthly fire drills are conducted, documented, and available.
    d. Emergency contact numbers are readily available and accessible to staff and individuals receiving supports.
4. Routine Inspections Ensure Environments are Sanitary and Hazard Free.
    a. The organization monitors housekeeping, conducts regular safety inspections, and completes routine maintenance and repairs to ensure safe conditions throughout any physical structures. A system is in place to immediately report and correct environmental or safety hazards.
    b. The organization maintains records of repairs and maintenance work and of internal inspections to ensure safety and sanitation. Indoor air pollution, inadequate heating and sanitation, structural problems, electrical and fire hazards and older homes with lead-based paint hazards must be addressed in the agency's monthly environmental rounds safety program.

c. Each organization adheres to the applicable certification and licensure standards, statutes, and regulations regarding the physical environment as required by the Alabama DMH Administrative Code Chapter 580-3-22 Minimum Standards for Physical Facilities.
    a. The organization maintains the appearance of the setting, inside and out, consistent with that of other settings in the neighborhood. This rule applies to Home and Community Based Services (HCBS) and settings.

## A.6.3.h Staff Resources and Supports

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30
**Effective:** October 1, 2020
**Revised:** June 3, 2025

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of staff resources and supports.

**Purpose/Intent:** To provide a process to ensure the provider practices sound management providing quality services to individuals.
HCBS Waivers: ID, LAH

**Key Terms:**
Tuberculosis (TB)
Qualified Developmental Disabilities Professionals (QDDP)

**Procedures:**
1. The Organization Implements a System for Staff Recruitment and Retention.
    a. The organization will recruit and hire staff in accordance with all applicable laws and organizational requirements.
    b. All employees/agents will have references and background checks prior to employment. A national background check is required. Volunteers who work unsupervised with individuals receiving supports will be subject to the aforementioned background check.
    c. Background checks must consist of the following personal identifiers; name, social security number, date of birth, and driver's license or state issued non-driver's identification. The following criminal activities will permanently disqualify a potential employee from employment:
        - Convictions for any crime of violence
        - Convictions for any felony
        - The following criminal convictions will prevent a potential employee from employment for the time specified:
            - Reckless endangerment in the past five (5) years
            - Stalking in the second degree in the past five (5) years
            - Criminal trespassing in the first degree in the past five (5) years
            - Violating a protective order in the past three (3) years
            - Unlawful contact in the first degree in the past (3) years
            - Unlawful contact in the second degree in the past year
            - Criminal mischief in the first degree in the past seven (7) years

d. The organization will complete pre-employment drug screening for each employee whose job duties involve the care, safety, and well-being of individuals, and on reasonable suspicion, for cause, of any employee of the organization.
e. The organization will require all new staff that have direct contact with individuals supported to have a Tuberculosis (TB) skin test with documented results, unless there is written evidence that such testing has been done within the last year unless there is a medical contraindication. The TB testing must be administered, read and documented by healthcare professionals who are not employees of the Direct Service Provider.
f. Annual TB testing of employees is not a requirement; however, the organization will annually provide documented ADMH approved TB education training for each employee who has direct contact with the individuals served. This annual education can be completed by healthcare professionals who are employees of the Direct Service Provider.
g. The organization will assess, at least annually, and adjust hiring practices based on analysis of position turnover, availability of qualified candidates, vacancy rates, staffing ratios, availability of financial resources, supports needed by individuals and other relevant data.
h. The organization will work with state and local resources such as schools and job placement services to ensure an adequate supply of qualified candidates.
i. The organization will conduct employee satisfaction surveys, including exit surveys when employees leave.
j. Satisfaction surveys will be reviewed for suggestions to improve recruitment and retention.

2. The Organization Implements Policies and Procedures That Promote Continuity and Consistency of Staff.
   a. The organization will have an adequate number of personnel and staff to carry out the stated purpose/mission
   b. Individuals supported will have adequate staff to provide needed services and supports so expectations, needs, and desired outcomes can be achieved.
   c. The organization will maintain records demonstrating staff accountability.
   d. The organization will maintain records demonstrating staff assignments and/or staff schedules.
   e. The organization's hiring practices, and staffing plan will be shaped by supports needed by, and individualized for, those receiving services.
3. Staff are Qualified for Their Roles.
   a. All employees who directly provide supports to individuals served under the Intellectual Disabilities and Living at Home (ID/LAH) Waiver shall meet the general Direct Support Professional (DSP) requirements outlined below, as well as any additional service specific qualifications required by state and federal law, the funding source, and applicable waiver requirements.

**General Direct Support Professional (DSP) Requirements**

- All Direct Support Professionals must:
- Be at least 18 years of age
- Meet all background screening requirements, including a statewide criminal background check
- Meet health and safety requirements, including pre-employment drug screening and tuberculosis (TB) screening, as required by agency policy and state regulations

- Successfully complete all required pre-service and ongoing training relevant to their assigned duties.

* The DSP position requires accurate interpretation and completion of written documentation throughout a workday. Therefore, ADMH – DDD expects all DSPs to possess the ability to read and write effectively.

a. Executive Directors/Owners/Operators will possess a bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field working with individuals with various disabilities or have a current Registered Nurse's license. The executive director will have considerable experience (5 or more years) working with individuals with intellectual and/or developmental disabilities in community settings. The director must possess, or be eligible for, license or certification in their particular field if applicable.
b. Support Coordinators at minimum, have a Bachelor of Arts or a Bachelor of Science degree, preferably in a human service-related field or social work program with specialized training and a four year college degree and will complete a Support Coordinator training program approved by the ADMH/DDD and the Alabama Medicaid Agency.
c. All Qualified Developmental Disabilities Professionals (QDDP) will have the minimum educational background required, Doctor of Medicine or osteopathy, registered nurse, or a bachelor's degree, in a human service field or a bachelor's degree with 12 hours course credit in a human services field.
d. All QDDPs will have at least one year of experience working directly with individuals with intellectual or other developmental disabilities and will complete QDDP training offered by the state.
e. Students completing a degree in psychology, counseling, social work or psychiatric nursing, will provide direct services only under the following conditions: the student is in a clinical practicum that is part of an officially sanctioned academic curriculum; receives a minimum of one hour/week direct clinical supervision from a licensed/certified mental health professional with at least 2 years post master's experience in a direct service functional area; and the student's clinical notes are co-signed by the supervisor. The organization will ensure employees maintain current certifications and licenses as required.

4. The Organization Implements an Ongoing Staff Development Program.
   a. The organization will assure orientation/training for each employee.
   b. The organization will maintain records documenting all employees training on site.
   c. Prior to assuming their assigned positions, all employees will complete training in each of the following areas:
      - Rights of individuals served
      - HCBS Settings Rule
      - Complaint/grievance procedure
      - Policies and procedures regarding abuse, neglect, mistreatment and exploitation
      - Overview of intellectual/developmental disabilities
      - Infection control/universal precautions
      - Severe weather preparedness
      - Fire Safety

d. Prior to working alone, and within at least 90 days of employment, all employees who provide direct supports to individuals will receive training in:
   - CPR (must receive certification)
   - First aid (must receive certification)
   - Medical emergencies
   - Management of aggressive behavior
   - Medication training including medication side effects
   - Signs and symptoms of illness
   - Incident identification/reporting in accordance with the IPMS

e. Prior to working alone, and within 90 days of employment, all staff who provide direct supports will receive training needed to implement individuals' plans.

f. Within 90 days of employment, all staff who provide direct supports to individuals will receive training in each of the following:
   - Agency policy and procedures
   - ii. Philosophy of self-determination
   - Person-centered supports
   - General behavioral principles with emphasis on skill acquisition and behavior reduction techniques

f. The organization will annually provide refresher training for all employees in each of the following areas:
   - Rights of individuals served
   - ii. HCBS Settings Rule
   - Complaint/grievance procedure
   - Policy and procedures on abuse, neglect, mistreatment and exploitation
   - Infection control/universal precautions

g. All direct support staff will be provided annual training in management of aggressive behavior.

h. Medication Assistant Certified (MAC) trained employees will be evaluated in compliance with the Nurse Delegation Program.

i. The staff training program will be developed based on input from individuals supported and their families/legally authorized representatives

j. Staff training will reflect current best practices

k. Training for staff will include one or more of the following:
   - Mentoring
   - ii. On the job support
   - Personal growth and development planning or Competency based measurement

l. All employees who provide direct supports will maintain current certifications in CPR and First Aid.

### A.6.3.i Positive Services and Supports

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30; Behavioral Services Procedural Guidelines (BSPG); Psychological and Behavioral Services (PBS) Procedural Guidelines

**Effective:** October 1, 2020
**Revised:** April 1, 2023

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of positive services and supports.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.

**HCBS Waivers:** ID/LAH

**Key Terms:**
Behavioral Services Procedural Guidelines (BSPG)
Psychological and Behavioral Services (PBS)

**Procedures:**

1. Individuals Are Informed About the Services and Supports the Agency Provides.
    a. The agency will discuss with the individual receiving supports and the legally authorized representative the organization's services and any related charges, including any limitations placed on the duration or services.
    b. The agency will provide a written statement of services and related charges to every individual receiving supports and the legally authorized representative.
    c. The agency will provide documentation to demonstrate learning opportunities provided to individuals served about Home and Community Based Service regulatory requirements and their right to due process should the provider modify those requirements.
    d. Individuals responsible for payment of charges for services must be informed of any changes in services or limitations placed on duration of services prior to their occurrence during the service relationship.
    e. The information must be provided to the individual in language and terms appropriate to the individual ability to understand.
2. Individuals Are Provided Assistance in Making Choices and Planning for Services and Supports.
    a. Each individual will have a support team that includes:
        - a Qualified Developmental Disabilities Professional (QDDP)
        - the legally authorized representative or advocate as needed,
        - family members (as desired by the individual and/or legally authorized representative),
        - representatives of all service providers (particularly staff responsible for program implementation), Support Coordinator, and others as indicated by the individual's life situation, needs, desires, and age (in the case of children), or as requested by the Individual or determined to be of important support.
    b. When individuals enter the program, the QDDP will share pertinent information regarding the individual's support needs, including medical care, safety concerns, etc. with Support Team members within 24 hours.
    c. There must be documentation included in the individual's record of information shared and those attending the initial support team meeting.
    d. Within 30 days of entry into the program, the team will meet to develop a Person- Centered Plan.
    e. The team will meet at least annually, every 365 days, to review and update the individual's plan.

f. The team will meet at the convenience of the individual and other members of the team to develop the Person-Centered Plan.
g. Each individual and his/her family members, or others with permission of the individual, must be invited to actively participate in Person Centered Plan meetings, and offered support to direct the plan to the extent the individual desires.
h. The individual and/or legally authorized representative must be prepared for the Person-Centered Plan meeting by sharing information to be discussed prior to the scheduled meeting, except in the event an emergency meeting is necessary. Information must be presented to the individual in a method, language, and/or terms appropriate for them to understand.

3. The Organization Assesses the Individual's Personal Goals and Priority Services and Supports.
   a. Each individual will have a current functional assessment. If the individual is new to the organization's services, the assessment must be completed no later than 30 days after entry into services.
   b. The functional assessment must be updated annually in conjunction with the Person- Centered Plan.
   c. The assessment will address all the following areas at a minimum:
      - individual's preferences,
      - family/home situation,
      - health needs,
      - activities of daily living,
      - vocational needs,
      - communication skills,
      - leisure activities,
      - physical supports, i.e., adaptive equipment, and
      - social supports
4. Individuals' Plans Lead to Person-Centered and Person--Directed Services and Supports.
   a. Individuals will have Person Centered Plans based on their strengths, interests, and needs.
   b. Person Centered Plans will focus not only on skills and supports available to the individual but on those are preferred by the Individual or needed to realize Individual goals as documented in the functional assessment.
   c. Person Centered Plans will include learning, participation and support opportunities that are meaningful, functional, and enhance the Individual's dignity.
   d. Information for Person Centered Plans must be obtained directly from the individual to the greatest extent possible or from others who know the Individual best.
   e. Information for Person Centered Plans will include observations of the Individual.
   f. Person Centered Plans will incorporate information from team members who know the individual well.
   g. Person Centered Plans must be modified by individuals with their support teams as needed, as soon as possible when there are significant changes in the Individual's physical or mental condition, and/or when a major life change is being contemplated by the individual or for the individual.
   h. The organization will have a clearly defined process for convening special Individual - centered planning meetings. Meetings must be called at any time mutually agreed upon by the Individual and/or advocate or legally authorized representative and his/her team.

i. Person Centered Plans will include prioritized goals designed to achieve desired individualized outcomes. Desired individual outcomes must be defined in such a way that they address the Individual's preferences, are attainable within a specific timeframe and enhance the Individual's life.

j. Goals will include participating in community life, gaining and maintaining satisfying relationships, having opportunities to fulfill respected social roles, expressing preferences and making choices, and continuing the development of Individual competencies.

5. The Organization Provides Continuous and Consistent Services and Supports for Each Individual.
   a. All identified formal supports will include implementation strategies defining who is responsible, when, where and how the opportunity is carried out, including the frequency, and methods of data collection to assess achievement.
   b. Staff will possess the knowledge, skills and abilities to implement Individuals' Person- Centered Plans as written.
   c. Staff will receive training in how to provide or access the supports needed to implement goals in each individual's plan.
   d. The organization will provide documented evidence that individuals are integrated in and supported to have full access to the greater community based on their individual needs and preferences as determined through daily interactions/conversations and as identified in their Person Centered Plan.
   e. The organization will have a system for ensuring that changes are effectively communicated to everyone within the organization who is important to the Individual or who provides supports to the Individual and ensures appropriate training if any special skills are needed.
6. The Organization Monitors the Effectiveness of Each Individual's Person Centered Plan.
   a. The organization will have a system to monitor implementation of Person Centered Plans that include direct observation of services and supports as well as reliable recorded evidence or information that reflects progress toward objectives and achieving desired outcomes.
   b. The implementation of Person Centered Plans must be reviewed and documented at least every 90 days for effectiveness.
   c. The review will include progress/achievement for each learning, participation, or service opportunity.
   d. Person Centered Plans must be modified by individuals with their support team if the individual is not benefiting from identified opportunities or as requested by the individual.
7. The Organization Provides Positive Behavioral Supports to Individuals.
   a. Person Centered Plans will include objectives and strategies to address behaviors that interfere with the achievement of individual goals or exercise of individual rights.
   b. Strategies to address behaviors will use the least intrusive interventions necessary and the most positively supporting interventions available.
   c. When appropriate, individuals will have Behavior Support Plans that reduce, replace, or eliminate specific behaviors.
   d. Behavioral Services Procedural Guidelines must be followed when implementing Behavior Support Plans.
   e. Behavior supports must be developed by a qualified professional based on information gathered in a functional assessment.

f. Functional assessments will identify physical and environmental issues that need to be addressed to reduce, replace, or eliminate behaviors.
g. Support plans will describe specific behavioral supports that may and may not be used.
h. Behavior Support Plans will include a plan to reach a functionally equivalent behavior that will take the place of a target/inappropriate behavior.
i. Direct support staff will receive training in behavioral techniques and plans prior to implementation of supports to individuals.
j. The organization will review data related to the effectiveness of behavior supports. The data is reviewed at least quarterly, or more often as required by individual needs.
k. Quarterly reports will summarize the behavioral/psychiatric symptom data.
l. Data will indicate whether the intervention(s) is effective.
m. Monitoring will include information explaining why behaviors/symptoms have worsened.
n. If no progress is made in three months, the Behavior Support Plan must be modified.
o. The report will include graph(s) of targeted reduction behaviors.

8. Individuals Are Free from Unnecessary, Intrusive Interventions.
   a. Prior to imposing a rights restriction, an assessment must be completed indicating the need for the restriction. The Individual will meet with the support team to discuss the reason for the proposed restriction, except in extreme emergencies to prevent the individual from harming self or others.
   b. Criteria for removing the restriction must be developed and shared with the individual, and legally authorized representative, prior to imposing the restriction.
   c. The individual, or the legally authorized representative, will give informed consent for any Behavior Support Plan that includes Level 2 or greater procedures.
   d. Behavior Support Plan that include Level 2 or 3 interventions must be reviewed and approved by the Behavior Program Review Committee, the Human Rights Committee, and the individual, or the individual's legally authorized representative.
   e. All reviews and approvals must be updated annually.
   f. Emergency or unplanned behavior interventions that are highly intrusive, level 3, will not be used more than three times in a six-month period without a team meeting to determine needed changes in the individual's Behavior Support Plan.
   g. If Individuals require behavioral or medical supports to prevent harm to themselves or others, supports must be provided in accordance with DDD-PBS 01-05.
   h. Restraint devices and other restraint procedures will only be applied by staff with demonstrated competency for the device/ procedure.
   i. The organization will ensure individuals are not subjected to highly intrusive behavior interventions or punishment for the convenience of staff, or in lieu of a Behavior Support Plan.
   j. The organization will prohibit the use of corporal punishment, seclusion, noxious or aversive stimuli, forced exercise, or denial of food or liquids that are part of an individual's nutritionally adequate diet.
   k. Requests for the use of Level 4 intervention procedures, except for Emergency Mechanical Restraint, must be sent to the Director of Psychological and Behavioral Services for the Division of Developmental Disabilities after reviews have been completed by the Behavior Program Review Committee, Human Rights Committee, and the legally authorized representative. All restraints approved through the BSP process must be documented in the Person-Centered Plan.

The QDDP will review at the frequency directed by the Director of Psychological and Behavioral Services.

l. The agency will document and comply with the limit for use of Emergency Mechanical Restraint as required by the IPMS.

9. The Organization Treats Individuals with Psychotropic Medications for Mental Health Needs Consistent with Standards of Care.
   a. The use of psychotropic medications for behavior support and use of medication to reduce or change behaviors associated with psychiatric symptoms will comply with provisions of DDD PBS Level 3, including incorporation into a Behavior Support and/or Psychotropic Medication Plan.
   b. PRN orders for psychotropic medications must be administered in accordance with Nurse Delegation Program and in compliance with emergency procedures and due process.
   c. The individual's Support Team will meet to assess and address behavioral and psychiatric needs when PRN medications are used as an emergency procedure three times within a six-month period.
   d. If an individual has a Psychotropic Medication Plan because they receive psychotropic medication(s) and have not exhibited a targeted behavior in six months, the Psychotropic Medication Plan must be reviewed and approved by the Behavior Program Review Committee at least annually.

## A.6.3.j Continuity and Personal Security

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30
**Effective:** Historical Practice
**Revised:** March 26, 2021

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of continuity and personal security.

**HCBS Waivers:** ID/LAH

**Procedures:**

1. The Governing Body Provides Leadership.
   a. Each organization will have a Governing Body which maintains and has the following documents/information available for review onsite:
      - written board approved operational policies
      - ii. articles of incorporation (or a charter) with bylaws
      - a current organizational chart that is updated regularly, but at least annually, and identifies the titles of employees
      - a written mission statement approved by the Board of Directors
   b. Responsibilities of the board must be defined in writing.
   c. Records/minutes of Board meetings will be maintained and available for review.
   d. The Executive Director will be responsible for the overall operation of the agency. This responsibility will be included in the job description for the Executive Director.

e. The organization will have a written mission statement consistent with its legal constituting documents describing its purpose, services/supports it provides, who receives services, and how expectations of those who receive services and supports are met.
f. The mission and values statement will clearly reflect the organization's commitment to protect individuals' rights.
g. The mission and values statement will reflect the organization's provision and availability of services through positive approaches that are dignified, respectful, and demonstrate achievement of outcomes unique to each individual.
h. The board will review the mission and values statements on a regular basis, but at least annually.
i. A system will be in place for receiving input from current and prospective service users in development of the organization's mission statement, values, and its ongoing organization and operations, as well as the opportunity to provide feedback to participants for required or desired changes
j. The system for providing input or feedback will be developed and maintained in a form that is easily used and understood by individuals receiving services and supports.
k. The organization will conduct flexible operations that meet individual needs in terms of accessibility and availability for those receiving services and supports.
l. The organization will maintain current certifications and licenses for operations and comply with all posting and notification requirements of local, state, and federal offices.

2. The Organization Supports Individuals to Manage and Access Their Personal Money.
   a. The organization will refrain from engaging in accounting/ fiscal practices that restrict individuals from having access to their personal money.
   b. The organization will, when assisting individuals with money management, provide the individual, legally authorized representative, and others identified by the individual with documented financial statements of all expenditures and excess funds at least quarterly.
3. The Cumulative Record of Personal Information Promotes Continuity of Services.
   a. The organization will maintain a cumulative record of information and documentation of services and supports needed by and provided to individuals.
   b. The organization will have:
      - a system for protecting the confidentiality of records, including financial and health information, in accordance with HIPAA regulations and other applicable state and federal laws.
      - ii. a system to ensure only those directly involved in an individual's care, or involved in authorized administrative review or service monitoring have access to records
      - a system for ensuring records are safe from loss, destruction, or use by unauthorized individuals.
   c. The organization will ensure that birth certificates, Social Security cards, eligibility paperwork, and other legal documents are maintained permanently, and all other records are maintained for five years
   d. The organization will ensure the individual's current record includes at least 12 consecutive months of information.
   e. The organization will ensure personal information includes only information needed to provide services and supports to individuals.
   f. The organization will ensure personal information contained in the record is accurate and legible.

g. The organization will ensure information is organized so it is accessible and able to be updated on a regular basis.
h. The organization will ensure individuals and their legally authorized representative have access to all individual information in their record and is able contribute to the information if they choose to do so.

## A.6.3.k Quality Improvement System

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30
**Effective:** October 1, 2020
**Revised:** March 26, 2021

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of a quality improvement system.

**Purpose/Intent:** To provide a process to ensure the provider practices sound management providing quality services to individuals.

**HCBS Waivers:** ID/LAH

**Procedures:**

1. The Organization Monitors Quality Improvement.
   a. The organization will have a written internal monitoring plan approved by their board of directors annually and will be available for review by designated DDD staff.
   b. The internal monitoring system will measure the most important elements and key functions of the organization.
   c. The organization will monitor, at a minimum, the following areas:
      - Promotion and protection of individual rights.
      - Dignity and respect practices.
      - Promotion of natural supports.
      - Protection from abuse, neglect, mistreatment, and exploitation, including implementation of an incident prevention and management system.
      - Best possible health, including implementation of the Nurse Delegation Program.
      - Safe environments.
      - Staff resources and supports.
      - Positive services and supports, including implementation of the Behavioral Services Procedural Guidelines.
      - Continuity and personal security.
2. A Comprehensive Plan Describes the Methods and Procedures for Monitoring Quality Improvement.
   a. The organization will clearly identify data sources, methods for data collection and the type of data analysis to be performed for each function measured.
   b. The organization will identify individuals responsible for collecting and analyzing data from the internal monitoring system.

c. The organization will identify responsibilities and roles of each individual involved on the internal monitoring team and include individuals supported.

3. Quality Improvement Monitoring Data is Used for Continuous Learning and Development.
   a. The internal monitoring system will emphasize quality enhancement and continuous improvement.
   b. Data collected, and information learned from the internal monitoring system will be used to inform and educate staff and individuals receiving services, improve systems, and ensure quality improvement is met.

## A.6.3.l Personal Care, Companion Care, Respite Care Crisis Intervention Services, and Supported Employment at an Integrated Worksite

**Responsible Office:** Offices of Certification
**Reference:** Administrative Code 580-5-30
**Effective:** October 1, 2020
**Revised:** March 26, 2021

**Statement:** This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of personal care, companion care, respite care crisis intervention services, and supported employment at an integrated worksite.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
HCBS Waivers: ID, LAH

**Key Terms:**
Electronic Visit Verification (EVV)

**Procedures:**

1. Staff Providing Services Know How to Support the Individual.
   a. In addition to administrative requirements in Chapter 580-5-30-.10, the organization will provide training to staff on the services to be provided and how the individual wants to be supported. This training will include:
      - Review of the Person-Centered Plan.
      - ii. Information about specific conditions and required supports of the individual to be served, including his/her physical, psychological or behavioral challenges, his/her capabilities, and his/her support needs and preferences related to that support.
      - Reporting and record keeping requirements.
   b. The organization will provide procedures for arranging backup workers when needed.
2. The Organization Develops and Implements a Person-Centered Plan.
   a. A Person-Centered Plan will be developed and approved for the individual receiving services, and there is documentation establishing that the plan is followed and is modified as needed.
   b. The Person-Centered Plan will be adequately detailed so the worker can provide the services required by the individual.
   c. The Person-Centered Plan will be approved by the Division of Developmental Disabilities. If services exceed twelve (12) hours per day of services, documentation must support the need.

d. If providing respite services, the organization will provide evidence that a temporary support plan was developed prior to the service and is documented and implemented for the individual while served by the organization.
e. The Person-Centered Plan will be developed with input from the individual, their legally authorized representative, family, and/or advocate.
f. If the individual's needs require more than twelve (12) hours of personal care or companion service per day, the individual and his/her team will meet to discuss a viable alternative service which will meet his/her needs.
g. If the individual and his/her team decides personal care, companion, respite, and/or crisis intervention services are no longer adequate, a viable alternative service will be located prior to discharge.

3. Services Are Monitored
   a. Documentation of the provision of identified services/supports will be available.
   b. A QDDP will be assigned to supervise the provision of personal care, companion, respite and crisis intervention services to the individual, evaluate the continued appropriateness of such services, and makes changes when the individual's needs or desires are not being met.
   c. The QDDP will conduct a site visit at least every ninety (90) days, and more often if needed. For Personal Care and Companion Care, QDDP on-site supervision must occur at least every 60 days, to include the required supervisory EVV log-in.
   d. The QDDP will assess the effectiveness of the service, individual/family satisfaction with the service, and institutes any changes that are needed.
   e. Documentation will be made establishing that the QDDP has taken corrective or improvement action in a timely manner, as need indicates.

## A.6.4 INCIDENT PREVENTION AND MANAGEMENT

**Responsible Office:** Offices of Assurance
**Reference:** Alabama Administrative Code §580-5-30-.05(1); Incident Prevention and Management System (IPMS) Manual
**Effective:** November 13, 2025

**Statement:**
An effective incident management system seeks to promote an environment that is free from harm. Toward that end, the Developmental Disabilities Division (ADMH-DDD) is committed to the following principles:

- All waiver participants are entitled to appropriate services that enable support and promote dignity, respect, and opportunities for personal growth and development that prevent harm without restricting individual freedoms and rights.
- Providers must eliminate, wherever possible, the occurrence of preventable incidents without unnecessarily restricting individual freedoms and choices.
- Providers must identify and respond appropriately to all types of incidents.

- Reducing the number of incidents, particularly serious incidents, helps create and perpetuate safe environments in which waiver participants are supported to live, work, and learn.

In 2016, ADMH adopted the Therap® incident management system, a web-based system to document relevant information about reporting, investigation, and follow-up of critical incidents for agencies providing services and supports for waiver participants. The Therap® system provides 24-hour access for all users to facilitate real-time critical incident reporting. The system provides a structured framework and process for providers to thoroughly and accurately document all information related to each critical incident including date, time, and person making the report; required notifications; identification of witnesses and persons having relevant knowledge of the incident who are interviewed; the processes and procedures used to conduct the investigation; the findings of the investigation; and any and all immediate and longer-term corrective actions resulting from the investigation. The Therap® system also serves as the repository of all documents associated with the critical incident investigation. In the Therap® system, critical incident reports are referred to as General Event Reports (GERs) and completed investigations and related documentation are referred to as GER Resolutions (GERRs).

Revisions to the IPMS Manual were made in response to the joint report issued by the U.S. Department of Health and Human Services, Office of Inspector General (OIG), the Administration for Community Living (ACL), and the Office for Civil Rights (OCR) which required increased oversight to improve health and safety of people receiving waiver services.

**Purpose/Intent:** The purpose of the ADMH-DDD Incident Prevention and Management System (IPMS) is to describe and implement through standard actions by the Division of Developmental Disabilities and contractors, a mechanism to protect waiver participants from harm, and improve the oversight and response capabilities of the systems that serve them. Protection from harm requires an incident management component that includes prevention, identification, classification, proper reporting, and investigation, and implementation of effective actions to remedy situations that lead to harm.

**Key Terms:**

Critical Incident

**Procedure:** All agencies are required to notify ADMH-DDD of all reportable incidents and act in accordance with the Incident Prevention and Management System policy, which includes state law and funding source requirements. Incident reporting, investigations, and follow-up processes must be followed as specified in the IPMS guidelines. Consideration must be given to specified timelines for reporting and resolution of incidents and investigations. Full cooperation is expected, including requests from the Bureau of Special Investigations (BSI) and ADMH Advocacy. Failure to submit information or respond to requests may prompt an agency investigation led by ADMH.

All requests by ADMH for information and corrective actions will be made in writing, either through Therap®, email, or certified mail, with a designated response date. Requests by ADMH to obtain information or evidence that corrective action has been implemented will be made to the Executive Director up to three times. Agencies that fail to cooperate with any request for information or corrective action will be subject to an immediate Provisional certification for a specified period. The Provisional certification status will remain in effect until either the requested corrective action is taken, information is provided, or specified certification date has expired. Failure to comply with documentation and/or corrective action requirements may also result in a For-Cause review. Furthermore, failure to cooperate

may result in decertification, termination of ADMH contract, or other enforcement actions due to noncompliance.

# CHAPTER 7
# BEHAVIORAL SERVICES

## A.7.1 BEHAVIORAL SERVICES PROCEDURAL GUIDELINES

**Responsible Office:** Offices of Psychological and Behavioral Services
**Reference:** ADMH Administrative Code 580-5-30-.02 (2), Behavioral Services Procedural Guidelines: DDD-PBS, HCBS ID/LAH/CWP Waivers
**Effective:** Historical Practice
**Revised:** February 23, 2024

**Statement:** The Alabama Behavioral Service Procedural Guidelines (BSPG) were established to provide oversight for behavior services with persons with intellectual disabilities in the state of Alabama who are served across the three HCBS Waiver programs (ID/LAH/CWP). The purpose of the BPSG is to provide information and guidance for the development and implementation of behavior services and apply to all providers and recipients of Positive Behavior Support services though the ADMH- Division of Developmental Disabilities HCBS Waiver Programs. The guidelines are intended to supplement the Community Standards used for certification of service agencies and the requirements of the Incident Prevention Management System (IPMS). 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 individuals 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 individuals 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.

**Key Terms:**
Behavioral Guidelines
Behavioral
Human Rights Committee (HRC)
Behavior Program Review Committee (BPRC)
Interdisciplinary Team (IDT)
Behavior Support Plan (BSP)

**Procedures:**
1. The Behavioral Services Procedural Guidelines outline the minimum requirements for providing Positive Behavior Support (PBS) services in the state of Alabama through the HCBS ID Waiver programs. The Behavioral Services Procedural Guidelines includes requirements for the development, implementation, and monitoring of a Behavior Support Plan using Positive Behavior Supports.
2. Anyone providing behavioral support services, as well as billing for positive behavior supports through ADMHDDD- HCBS waiver services must have received training on the AL Behavioral Services Guidelines (also called the Positive Behavior Supports Orientation) provided by the Office of Psychological and Behavioral Services.
3. The Behavioral Services Procedural Guidelines details four levels of interventions used in providing

an individual supports, with each successive level indicative of greater restrictiveness, such that Level1 procedures are not restrictive at all and Level 4 is highly restrictive. All level 4 procedures must be approved by ADMH via the regional RFA process, and only after the Person-Centered Plan and BSP.

4. Each BSP containing Level 3 Procedures requires prior approval by the Behavior Program Review Committee (BPRC), review by the Human Rights Committee (HRC), and approval/consent by the individual or the parent/guardian and must be reviewed and updated at least annually. Of note, Specialized Staffing (i.e., increased staffing supervision) and Restriction of Personal Items, Phone Calls, Visitors, etc intended to mitigate behavioral risk (not medical) are considered a Level 3 Procedure and must be included in a BSP.
5. Level 4 Procedures are considered the most restrictive and must be included in a BSP (exception is Emergency Mechanical Restraint, which has an IPMS documentation requirement and a limit regarding the number of times it can be used). Level 4 Procedures must receive ADMH-DDD approval prior to use and for continued use. They must be reviewed and approved by submitting RFA to Community Services Regional Office with request to use specific Level 4 procedures (accompanied by the individual's BSP, supporting data, and documentation relevant to the request), in addition to approvals from client/guardian, IDT, HRC, and full BPRC. Reviews by both the BPRC and HRC committees include that they ascertain whether less restrictive procedures have been tried and documented to have been ineffective prior to approving restrictive procedures, including restraints.
6. The Behavioral Services Procedural Guidelines describe the procedures referenced as restraint, along with the requirements for monitoring and documenting those procedures. Providers are required to train all staff who must implement restraints in the appropriate application of the procedures.
7. It is recommended a copy of the Guidelines be made available at the site where services are taking place, for all who are involved in day-to-day behavioral services, and ALL HCBS providers and related staff should be trained on its contents.
8. Requests for training related to behavioral services can be made through the Director of Psychological and/or Behavioral Services and regional Comprehensive Support Services Teams.

**Please click the link below to access form:**

**ADMH – DDD BEHAVIOR SUPPORT PLAN CHECKLIST FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/ADMH-DDD-Behavior-Support-Plan-Checklist.pdf

## A.7.2 BEHAVIOR SUPPORT PLAN WRITING AND CONTENT

**Responsible Office:** Offices of Psychological and Behavioral Services
**Reference:** ADMH Administrative Code 580-5-30; Behavioral Services Procedural Guidelines: DDD-PBS, HCBS Waiver Manual
**Effective:** April 1, 2021
**Revised:** February 23, 2024

**Statement:** An individual receiving HCBS waiver services from the Alabama Department of Mental

Health, Developmental Disabilities Division, is required to be provided with a Person- Centered Plan of services, which could include a Behavior Support Plan where applicable.
Purpose/Intent: To provide content required specific to a Behavior Support Plan, which will assist in the efficacious provision of Positive Behavior Supports**.**

**HCBS Waivers:** ID/LAH

**Key Terms:**
Behavior Support Plan:
Functional Behavior Assessment (FBA)

**Procedures:**
1. The Behavioral Services Procedural Guidelines require that, for *any* person exhibiting behaviors that interfere with the implementation of the Person-Centered Plan, a BSP must be designed and implemented to:
   a. Reduce those undesirable behaviors
   b. Describe needed alterations to the environment to reduce or remove triggers to undesirable behaviors
   c. Describe procedures to promote and encourage existing desirable behaviors
   d. Teach new acceptable behaviors that are effective to obtain desired outcomes for the person involved
   e. Describe procedures to be used by staff to respond to dangerous or undesired behaviors when they occur
2. A Behavior Support Plan (BSP) is needed when the identified behavior is:
   a. Dangerous to others
   b. Dangerous to self
   c. Destructive (property damage, costly to repair/replace)
   d. Barrier to Independence (specific acts that are against the law – stealing; illegal sexual acts)
   e. Barrier to integration into the community at large (i.e. stripping in public; entering personal
3. The BSP should provide clear descriptions of behaviors of concern and explicit instructions to staff on the actions they are to take to provide training, reinforce desired behaviors, modify the environment, respond to target behaviors, and tabulate data. A copy of the data sheet(s) to be used in carrying out the BSP should be included as part of the instructions for the BSP.
4. The BSP consists not only of the written plan but also its implementation.
5. There should be evidence of staff training and competence in carrying out the BSP.
6. Implementation of the BSP must demonstrate adequacy of the measurement method, including tabulation on forms that promote accuracy in recording and guidance to staff regarding the procedures used to count behaviors. A copy of the data sheets used in carrying out the BSP should be included as part of the instructions for BSP. The data recording form is considered a component of the BSP, and training in its use is a part of the implementation.
7. During implementation of the BSP, decisions regarding treatment effectiveness and the need for changes in treatment are made. Data must be presented and be adequate to justify the inferences drawn from them.
8. **CONTENT-** The BSP must include:
   a. Demographic and operational information
      - Name, date of birth, and age of the individual
      - Author(s) of the plan and supervising BCBA if applicable

- Date of implementation of the plan
- Restriction level of the plan and listing of all restrictions

b. The goal or purpose of the BSP (e.g., reduce hitting of others, running away from staff, and refusing medications; teach requesting reinforcers, waiting in line at store check-out, brushing teeth)

c. Historical information
Information relevant to current behaviors, including prior behavioral strategies and their outcome. Include prior restrictive interventions if applicable.

d. Diagnostic information
All diagnoses, psychiatric, cognitive, and medical (e.g., autism, ID, anxiety, genetic disorders, etc.)

e. Medications
Psychotropic and non-psychotropic medications with name of medication, dosage, and associated diagnosis and symptoms

f. Target Behaviors
- Define each behavior of concern in terms that can be recognized when they occur.
- If applicable, describe observable behaviors that indicate a psychiatric event is occurring (e.g., staring into a dark corner and speaking to the corner) and the method(s) for counting them when they happen.
- Include 12 months of data if available; specify type of data collection (e.g., average number of occurrences per hour, graphed by average per day; daily average number of 15-minute intervals within which the behavior occurred, etc)

g. A summary of the Functional Behavior Assessment, the hypothesized functions of target behaviors, and strategies to deal with them. List the source of information (direct observation, staff interview), describe settings, antecedents of behaviors, and maintaining factors.

h. Behavioral goals: Describe measurable goals for learning desirable behaviors and methods to be used to teach them and measurable goals and teaching strategies for reduction of undesirable behaviors.
- Descriptions of antecedent modifications. Strategies that include reinforcement, changes to the environment, teaching of replacement behaviors, that make desired behaviors more likely and undesirable behaviors less likely.
- A description of the replacement goals for each targeted behavior.
- Specific procedures for staff to follow when target behaviors and crisis situations occur.

i. The supports needed to implement the procedures outlined.

j. Listing of all restrictive procedures:
- Name of the procedure
- Level of restriction
- Justification for inclusion in the BSP
- Removal criteria—the plan for fading/removing the restriction.
- Frequency of review
- Brief description of previous and current efforts to fade restrictive interventions.

k. Data collection methods and monitoring of the plan
- How staff will collect data both for target behaviors and for training
- Who will monitor the plan and when

l. Methods for staff competency training and monitoring of program implementation

m. Due process safeguards.

n. Signatures of:

- Individual served
- Guardian (if applicable)
- Plan author
- BCBA supervising the Plan
- BPRC review and approval
- HRC review and approval

**Please click the link below to access form:**

**ADMH – DDD BEHAVIOR SUPPORT PLAN CHECKLIST FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/ADMH-DDD-Behavior-Support-Plan-Checklist.pdf

## A.7.3 SPECIALIZED BEHAVIOR SERVICE PROVIDER

**Responsible Office:** Offices of Psychological and Behavioral Services
**Reference:** Home and Community Based Waiver Programs
**Effective:** September 20, 2021

**Statement:** Providers that are approved through the Alabama Department of Mental Health-DD Division will deliver Medicaid waiver program services to population of individuals with specialized behavioral needs that place them at risk for psychiatric or behavioral crisis, displacement, hospitalization, homelessness, or incarceration. Services offered in this setting are provided by staff with specialized competencies related to crisis response, dual diagnosis issues, and behavioral programming.

**Purpose/Intent:** This provider category is designed to serve individuals with specialized needs utilizing an IRBI-based rate intended to allow for staff (specifically, Direct Support Professionals) to receive a higher rate of pay for the provision of more behavior intensive services. It is not required that providers use this rate for all individuals with high-risk needs requiring a BSP, rather it is a category intended to build provider capacity and knowledge for intensive behavior supports for those who are interested.

**HCBS Waivers:** ID/LAH

**Key Terms:**
Regional Community Services (RCS)
Request for Action (RFA)
Board-Certified Behavior Analyst (BCBA)
Behavior Support Plan) (BSP)

**Procedures:**
1. To access the Specialized Behavior Service Provider rate for an individual, the procedures are listed below and must be completed before the rate can be utilized:
   a. Once the provider has completed the requirements (listed in next section) to be approved as a Specialized Behavior Service Provider and have identified an individual to serve, they would follow the standard Request for Action (RFA) process (see RFA O.G.) and list “Specialized Behavior IRBI” on the Other line when indicating what services are being requested.

b. All BSPs, Person Centered P, Psychotropic Med Plans, Identification of BCBA providing services, and proof of staff completion of Relias Course Curriculum must be submitted with the RFA.
c. Once the RFA has been approved, the Specialized Behavior IRBI should be completed and submitted to your RCS Director for approval.

2. To qualify to provide Specialized Behavior Services under this category, the requirements are listed:
   a. Individual served must have specialized behavioral needs- evidenced by:
      - an initial screening by a Regional Psych and Behavioral Evaluator
      - a clear and present danger to self and/or others if not for structured and consistent services.
      - Specialized rates will be approved in 90- day increments on information provided and reviewed as part of the individual's Person-Centered Plan (PCP).
   b. Provider must utilize Board Certified Behavior Analyst (BCBA) Services- The agency must employ or have access to consult with a BCBA to complete and document all:
      - Functional assessments for individuals identified to need a BSP to include the use of staffing restrictions, restraints, and/or supports to address challenging behaviors. A
      - (BPRC) and the Human Rights Committee (HRC).
      - BCBA-Medication Plans. Individuals who take Psychotropic Medication, a formal Psychotropic Medication Plan is required. A QDDP can develop the plan which, can be part of the BSP or a stand- alone document. However, the BCBA should review and approve prior to review by the BPRC and the HRC.
3. Provider must adhere to requirements for staff competency and training- Staff, to include the BCBA, QDDP, and DSPs who will be working with the individual meeting criteria for this service, must complete a set of courses established by ADMH-DDD and is listed below. Additional training requirement includes orientation on the Alabama Behavioral Services Procedural Guidelines (also known in the waiver manual as the Positive Behavior Support Orientation).
   **RELIAS Curriculum for Specialized Behavior Services (Course List)**
   a. Crisis Intervention for Individuals with Developmental Disabilities
   b. Supporting Individuals with IDD and Mental Health Conditions
   c. Introduction to Trauma Informed Care
   d. Providing Support for Challenging Behavior

The course curriculum can be found here: https://admh.academy.reliaslearning.com/ADMH-DDDSpecialized-Behavioral-Services-Provider-Training-Plan.aspx, $70 total for 4-course bundle.

ADMH-DDD will reimburse provider agencies for the completed course bundles. Providers should submit invoice to Regional Office Fiscal Manager along with proof of completion for each staff participating.

The BCBA and/or QDDP must provide the DSPS training/guidance on the implementation of individual's BSP, and this must be provided prior to the direct support staff working with an individual and at least quarterly thereafter. This training must be documented by the BCBA and/ or QDDP and maintained by the provider on all direct support staff. BSP training notes/records should be submitted along with quarterly IRBI approval information.

**Please click the link below to access form:**
**DMH – DDD BEHAVIOR SUPPORT PLAN CHECKLIST FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/ADMH-DDD-Behavior-Support-Plan-Checklist.pdf

## A.7.4 REQUEST FOR ACTION FOR SPECIAL LEVEL OF STAFFING RESTRICTIONS

**Responsible Office:** Offices of Community Programs
**Reference:** ADMH/DD Operational Procedures
**Effective:** Historical Practice
**Revised:** November 19, 2021
**Reviewed:** March 5, 2024

**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 Services Procedural 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.

**HCBS Waivers:** ID, LAH

**Key Terms:**
Regional Community Services (RCS)
Request for Action (RFA)General Event Report (GER)
Behavior Support Plan (BSP)
Individual Residential Budgeting Instrument (IRBI)
Division of Developmental Disabilities Information Management System (DDD IMS)
Psychological and Behavioral Evaluator (PBE)

**Procedures:**
If a supported individual's interdisciplinary team recommends a special level of staffing restriction for behavioral or medical supports, prior to a team meeting, the Provider submits to the Support Coordinator documentation detailing the special level of staffing restriction requested and provides (at minimum) the following documentation:

**Supports for Behavioral concerns:**

a. Current Behavior Support Plan, including a realistic and attainable plan for fading of special level of staffing restriction and all required approvals
b. 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).
    1. Data on fading periods (if applicable)
    2. 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)
    3. When staffing is utilized 24 hours/day, data must be submitted on hours slept per night and behaviors that occur during overnight hours separate from behavior frequency data during awake hours
    4. GER's related to behavioral issues and restraint (manual, mechanical, and chemical) per reportable incident definitions
c. Interdisciplinary team meeting 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
- If no progress is made in three (3) months, or if behaviors significantly increase, the Behavior Support Plan must be modified

**Supports for Medical concerns:**

d. Detail on other interventions including use of adaptive equipment that has been attempted
e. Detail of supports that are required due to medical status
f. Most recent physical/medical assessment
g. Documentation/data on incidences related to medical condition (if applicable)
h. Current Status (i.e., progression, regression, or no change)
i. The time frame of special level staffing approval for medical supports will be determined based on individual needs and data/information regarding medical concerns

2. The Support Coordinator uploads these documents to DDD IMS Notes and tags the Regional Office Psychological and Behavioral Evaluator (PBE).
3. Regional PBE reviews the RFA and associated documentation for completeness and compliance with Operational and Behavioral Guidelines. Medical requests are reviewed, and recommendations made by the Community Services RN.
4. If questions or incomplete/insufficient documentation, PBE responds to the Support Coordinator to request additional information via DDD IMS notes.
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 special level of staffing restriction, 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 individuals 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, PBE makes a determination based on individual progress, factors in data/BSP (e.g., data trends, fading criteria, etc.), and on Behavioral Services Procedural Guidelines.
8. A final determination is communicated to the Support Coordinator via DDD IMS notes.
9. The Support Coordinator communicated this determination to the Provider within three (3) working days.

**Note: <u>In cases where either Behavioral or Medical supports are needed emergently due to sudden changes with an individual's situation; requests can be made directly to the Community Services Director for temporary approval</u>.**

## A.7.5 COMPREHENSIVE SUPPORT SERVICES (CSS) TEAMS

**Responsible Office:** Offices of Psychological and Behavioral Services

**Reference:** ADMH Administrative Code 580-5-30-.02 (2); ADMH Policy 540-1
**Effective:** Historical Practice
**Revised:** April 1, 2023
**Reviewed:** February 23, 2024

**Statement:** When people with intellectual disabilities served or on waitlist through one of the Alabama DMH Division of Developmental Disabilities (DDD) Home and Community Based Settings (HCBS) Waivers experience behavioral challenges or have need for interventions to prevent behavioral crises, the DDD established clinical professionals with advanced training in behavioral support services who are part of what is known as Comprehensive Support Services (CSS) Teams to provide consultation.

**Purpose/Intent:** The CSS teams were originally established to provide transition assistance and guidance for individuals with intellectual disabilities who were transitioning from institutional settings to home and community-based settings as a way to aid in successful outcomes and mitigate crises situations that may have occurred. The current program structure allows for the assistance and guidance to be available to the waiver participant, and where applicable, their family/natural supports, involved provider agencies, mental health centers, police and other community support organizations. This consultation service is intended to address significantly challenging, crisis related, and/or other behavior/mental health related situations that may lead to an individual experiencing psychiatric hospital admission, incarceration, or challenges to maintaining community living. Consultation services are designed to increase the individual's coping and behavior regulation skills, and to increase the capacity and expertise of those involved in supporting the person, in the places where the person is being supported.

**HCBS Waivers:** ID, LAH, CWP

**Key Terms:**
Individuals eligible for services provided by CSS Teams

**Procedures:**
1. CSS teams assess the need for and assist with providing an array of supports to individuals who require specialized behavioral services, and if available, medical, psychiatric, and/or dental consultation that when needed specifically due to behavior that is challenging.
2. CSS Teams provide training, information and resources to the greater service community at large to assist them in developing internal capacity related to supporting individuals with intellectual disabilities who require their services.
3. Comprehensive Support Services teams are located within the five ADMH-DDD Regional Community Services offices, and offer state-wide coverage.
4. Consultation Services Provided:
    a. Training- for Staff, agencies, support persons, and other community members on behavior related topics, procedures, and/or ADMH Behavioral Services Procedural Guidelines
    b. Recommendations - regarding individual experiencing behavioral challenges or acute changes

c. Technical Assistance- review related to Behavior Support Plans/Psychotropic Med Plans, guidance data and behavior tracking
d. Clinic - Medical/Dental/Psychiatric Telehealth Consultative services. Who should be referred:
    - Persons with ID who are receiving HCBS Waiver program services and are exhibiting challenging behaviors with the potential to escalate into a crisis situation; or are experiencing behavioral challenges that are high risk, and/or harmful to self or others; or exhibiting behaviors that may lead to experiencing psychiatric hospital admission, incarceration, or challenges to maintaining community living.
    - Those for whom current behavioral or medical/dental treatment strategies are not effective for a person otherwise eligible for services provided by CSS Teams
    - Persons who have numerous psychotropic medications or high doses prescribed
    - Persons who have begun exhibiting new challenging behavior(s)
    - Persons who have had recent psychiatric/behavioral hospitalization(s) and need guidance for implementing new strategies once back in community environment

5. Involvement with law enforcement due to challenging behaviors

- Accessing Services: In order to access Comprehensive Support Services Team consultation, provider agencies, families, and/or other primary support persons families should contact their assigned Support Coordinator who will communicate requests to the applicable Regional Community Services Office. Procedures have been established for processing and prioritizing referrals using the Request for Regional Action (RFA) procedures and CSS Consultation form (see Steps for Referring to CSS and CSS Consultation Form these have already been submitted). For persons with questions related to CSS Team services not covered within this operational guideline, please contact the ADMH DDD Director of Psychological and Behavioral Services.

## A.7.6 ID/DD DUAL DIAGNOSIS CRISIS

### A.7.6.a ID/DD Dual Diagnosis Crisis

**Responsible Office:** Offices of Psychological and Behavioral Services
**References:** ADMH-DDD Crisis Inpatient Referral Form; ADMH-DDD Behavior Support Plan Checklist
**Effective:** June 1, 2021
**Reviewed:** February 23, 2024
**Revision:** March 3, 2025

**Statement:** ADMH-DDD recognizes the need for increased resources relative to the service gap regarding mental/behavioral health crisis for individuals with intellectual and developmental disabilities statewide. A partnership between ADMH-DDD and Alabama area hospitals has been established to assist in addressing this need.

**Purpose/Intent:** The applicable inpatient psychiatric hospital purposes to provide ADMH-DDD Crisis Care services through short-term acute inpatient psychiatric treatment and stabilization to children and adults. Referral and treatment processes are described in the following procedures.

**HCBS Waivers:** ID, LAH

**Procedures:**

1. The individual must be referred by the AL Department of Mental Health- Division of Developmental Disabilities Central Office (ADMH-DDD) and have evidence of an Intellectual and/or Developmental Disability diagnosis AND be in an active Mental or Behavioral Health Crisis.
2. The individual must be medically manageable and able to participate in a psychosocial treatment plan on the unit. Individuals who are medically unstable, bedfast, or requiring high acuity medical care by a medical specialty are not appropriate for the unit.
   make referral for inpatient crisis care. Any Behavior Support Plans and/or Psychotropic Medication Plans (where applicable) should be submitted with intake form.
3. The individual should meet one or more of the following criteria to establish medical necessity for inpatient psychiatric care:
   a. Has recently (within 72 hours) attempted suicide or has explicit suicidal thoughts.
   b. Has been physically assaultive to a degree that threatens the life or safety of other individuals.
   c. Has engaged in significant self-injurious behavior.
   d. Is suffering from an acute onset or exacerbation of psychotic symptoms, such as hallucinations (auditory, visual or both), suicidal or homicidal ideation, of sufficient severity to jeopardize the individual's ability to live safely outside of a hospital.
   e. Acute deterioration of the individual's behavior, coping skills, or ability to care for self to a degree that creates a risk of harm to self or others.
4. If the individual meets criteria for short term acute inpatient care as defined above, inpatient resources in their region/area should first be explored and ruled out as available options. Crisis care resources should also be explored and considered.
5. Provider/caregiver/representative/Support Coordinator will complete the ADMH-DDD Crisis Intake Referral Form specific to the individual's demographic (i.e. Children's/adolescents or adult setting) and contact their Regional Community Services Director to make referral for inpatient crisis care. Any Behavior Support Plans, current medication list, guardianship paperwork (where applicable), and previous hospitalization discharge notes (where applicable)should be submitted with intake form.
6. The Provider/caregiver/representative must agree to active participation in treatment and discharge planning, as well as accepting of consultation from ADMH-DDD in transitioning the individual back to the pre-crisis environment once stabilized. This is acknowledged through signature of the referring provider in the applicable section on the referral form.
7. Regional CSD will review information submitted to ensure individual meets criteria described above and that all necessary documentation is complete. Upon completion of review, the Regional CSD will make recommendation for hospitalization to the ADMH-DDD Central Office. Referral would then be sent to hospital and all referring individuals will be included in communications related to admission, treatment, and discharge.

**Please click the link below to access form:**

**ADMH – DDD CRISIS INPATIENT REFERRAL FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/ADMH-DDD-Crisis-Inpatient-Referral-Form.pdf

# CHAPTER 8
# WAIVER SERVICE GUIDANCE

## A.8.1 INDIVIDUALIZED RESIDENTIAL BUDGET INSTRUMENTS (IRBIs)

### A.8.1.a For DMH and DHR Funded School Aged Children *(Removed)*

### A.8.1.b Absentee Rates *(Removed)*

### A.8.1.c Residential Rate Completion and Workflow

**Responsible Office:** Offices of Administrative and Offices of Fiscal Operations
**Effective: Historical Practice**
**Revised:** February 21, 2025

**Statement:** Party responsible for completion of residential rate tool and workflow after completion.

**Purpose/Intent:** To outline the responsible party for completion of IRBI, technical support available and workflow after completion.

**HCBS Waivers:** ID, LAH

**Key Terms:**
Department of Mental Health (DMH)
Request for Regional Action (RFA)
Person-Centered Plan (PCP)

**Procedures:** Residential providers will bear the responsibility of completing the residential rate tool on people served in residential settings when the individual is placed with the program and when any changes are needed in the residential rate tool for staffing coverage (to be approved through the RFA process). If help is needed with completing the residential rate tool, the provider should contact the Fiscal Manager in their respective regional office. Regional Fiscal Managers will assist in the completion, given the request for staffing needs from the provider. The provider will then complete the residential rate tool and send it to their Regional Community Services Director. The director will check the residential rate tool to ensure it aligns with the context of the person-centered plan.

When approved, the residential rate tool will be scanned into ADIDIS by regional office staff.

If the residential rate tool in ADIDIS does not match current approved staffing at redetermination, an updated residential rate tool should be included with the individual's annual redetermination packet. The residential rate tool template is posted on the Department's website.

The residential rate tool will be reviewed, in conjunction with an individual's PCP, by regional office staff before a site is monitored.

## A.8.2 PROVIDER RECOUPMENT GUIDELINES *(Removed)*

## A.8.3 PUBLIC HEALTH EMERGENCY

### A.8.3.a Covid-19 Infectious Disease Emergency Plans for Direct Support Providers *(Repealed)*

### A.8.3.b Covid-19 Appendix K - Temporary Presumed Eligibility During a State of Emergency *(Repealed)*

### A.8.3.c Assistive Technology & Virtual Service Guidance via Appendix K/PHE2020 *(Repealed)*

## A.8.4 HOUSING SPECIALIST ACCESS REQUEST

**Responsible Office:** Offices of Regional Community Programs
**Reference:** DDD HCBS Waivers
**Effective:** Historical practice
**Revised:** March 10, 2025

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

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

**Key Terms:**
Request for Action (RFA)
Interdisciplinary Team (IDT)
Person-Centered-Planning (PCP)

**HCBS Waivers:** ID, LAH

**Procedure:**
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 Community Transition 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 Community Transition 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 Community Transition 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.

## A.8.5 MEMORANDUM OF AGREEMENT FOR NON-CONTRACTED HCBS SERVICES *(Repealed)*

## A.8.6 HCBS WAIVER SERVICE GUIDANCE ON NURSE DELEGATION FOR MEDICATION ADMINISTRATION

**Responsible Office:** Offices of Community Programs
**Reference:** ABN Regulation 610-X-6-.01; ABN 610-X-7-.06
**Effective:** December 1, 2021

**Statement:** The nurse delegation program sets forth certain requirements regarding medication administration.

**Purpose/Intent:** This OG provides an overview of expectations for NDP as it related to Person-centered Planning and medication administration.

**HCBS Waivers:** ID, LAH

**Key Terms:**
Person-centered Planning (PCP)
Direct Support Professional (DSP)
Registered Nurse (RN)

**Procedures:**

1. The person-centered planning (PCP) team, including the individual and others who know the individual well (e.g., family; guardian) will determine if an individual needs assistance with medication administration that is subject to nurse delegation by a MAS Registered Nurse (RN) and the direct assistance with medication administration by a MAC certified direct support professional (DSP).
2. To assist the PCP team in determining if any supports for medication administration are needed, and if yes, the type of supports needed, the following guidance should be considered:
   - Nurse delegation by a MAS Nurse (RN/LPN) and the direct assistance with medication administration by a MAC direct support professional (DSP) is not required in the following situations:
     a. When the person can self-medicate with verbal reminders, verbal prompts, gestures and/or modeling (if needed) from natural supports or DSPs delivering HCBS Waiver services.

**Note: In these situations where only verbal reminders, verbal prompts, gestures and/or modeling by the DSP may be needed, the DSP delivering the HCBS Waiver services does not have to be MAC certified. Also note that, if effective for the individual, verbal reminders, verbal prompts, gestures**

**and/or modeling by the DSP can be done virtually using remote audio/video technology as appropriate for the individual.**

3. When natural supports (E.g., family; other natural supports the person may live with, work with, or spend time with) provide any needed assistance with medication administration including both verbal and physical assistance.

**Note: Paid DSPs should not supplant natural assistance otherwise available to the person.**

**Note: If a natural support is being paid to support the person at certain times the following is true:**

Nurse Delegation applies (and the natural support must be MAC certified) if the natural support is being paid when s/he is assisting the person with medication administration in a way that requires Nurse Delegation (i.e., a way that involves the natural support touching/handling the medication).

Nurse Delegation DOES NOT apply (and the natural support must NOT be MAC certified) if the natural support is NOT being paid when s/he is assisting the person with medication administration in a way that requires Nurse Delegation (i.e., a way that involves the natural support touching/handling the medication).

- If a person has difficulty removing medication from the bubble pack that they come in, consider a different medication system. Options include:

4. A medication administration device that is filled by the pharmacy and that dispenses the appropriate medication(s) and dosage(s) at pre-set times with an alarm to remind the person it is time to take medication.

**Note: These devices sometimes include technology to monitor if the medication has been removed from the device at the appropriate time, which further ensures the person takes their medication timely.**

**Note: A DSP or natural support can also provide verbal reminders, verbal prompts, gestures and/or modeling (if needed) and the DSP does not have to be MAC certified, nor does nurse delegation apply.**

**Note: These devices cannot be filled with controlled substances so if a person takes a controlled substance, this would not be an option for that particular medication**.

5. Individual dose packets with tear-off seam similar to individual dose packets of over-the-counter drugs (E.g., Advil, Tylenol).
   - If a person needs assistance from a Self-Direction DSP with medication administration that requires Nurse Delegation (i.e., a way that involves the Self-Direction DSP touching/handling the medication), the Self-Direction DSP needs to be MAC certified and supervised by an RN/LPN who has gone through MAS training. The RN/LPN's involvement is covered through a Skilled Nursing authorization.
   - Annually, as part of the person-centered planning process, for any HCBS Waiver service enrollee who is not self-administering medication, the PCP team should give consideration to the HCBS

Waiver service enrollee's ability and desire to learn to self-medicate and how supports to encourage and train the HCBS Waiver service enrollee to self-medicate can be incorporated into the PCP.

- A Medication Self-Administration Assessment Form (NDP-5) is only done if the PCP team concludes a person may need a MAC-certified DSP to physically handle and/or administer medication to a HCBS Waiver service enrollee. This Assessment must be completed by a MAS trained RN or LPN.
- A comprehensive assessment is only completed if Skilled Nursing is being authorized to include delegation as a service or as a component of another service. A comprehensive Assessment may be initiated by the MAS LPN and verified by the MAS RN.

# CHAPTER 9
# WAIVER SERVICE DESCRIPTIONS

## A.9.1 ID AND LAH WAIVER SERVICE GRID *(Removed)*

## A.9.2 SUPPORTED EMPLOYMENT

### A.9.2.a Discovery Assessment/Profile

**Responsible Office:** Offices of Employment Services
**Reference:** ADMH Administrative Code 580-5-30; Medicaid Administrative Code
**Effective:** Historical Practice

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

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

**HCBS Waivers:** ID/LAH

**Key Terms:**
Discovery

**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 120 units (30 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 10 hours or 40 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 10 hours or 40 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 10 hours or 40 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.

### A.9.2.b Pre-Vocational Services- Pathway to Employment

**Responsible Office:** Offices of Employment Services
**Reference:** ADMH Administrative Code 580-5-30; Medicaid Administrative Code
**Effective:** Historical Practice

**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 employment and are not job-task oriented, but instead aimed at a generalized result.

**HCBS Waivers:** ID/LAH

**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 2470 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 2470 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.

### A.9.2.c Vocational Rehabilitation

**Responsible Office:** Offices of Employment Services
**Reference:** Medicaid Administrative Code
**Effective:** Historical Practice

**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.

**HCBS Waivers:** ID/LAH

**Definitions:**
Supported Employment (SE)

**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 A.9.2.a. 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 9.5. 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 A.9.5. 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 A.9.2.d.1. 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.

## A.9.2.d Individual Supported Employment Services

### A.9.2.d.1 Job Developer

**Responsible Office:** Offices of Employment Services
**Reference:** ADMH Administrative Code 580-5-30; Medicaid Administrative Code
**Effective:** Historical Practice

**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.

**HCBS Waivers: ID/LAH**

**Key Terms:**
Job Developer

**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.

### A.9.2.d.2 Job Coach

**Responsible Office:** Offices of Employment Services
**Reference:** ADMH Administrative Code 580-5-30; Medicaid Administrative Code
**Effective:** Historical Practice
**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.

**HCBS Waivers:** ID/LAH

**Key Terms:**
Job Coach

**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 individuals 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 analyses through employer interviews, actual job performance to ensure 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 timecard, 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 individuals 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 individuals in supported employment;
8. Performing other job duties necessary to ensure the success of individuals 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 workplace.

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.

## A.9.3 SUPPORTED EMPLOYMENT SMALL GROUP

**Responsible Office:** Offices of Employment Services
**Reference:** ADMH Administrative Code 580-5-30; Medicaid Administrative Code
**Effective:** Historical Practice

**Statement:** Services and training activities provided in a regular business or industry in community settings for groups of two (2) to four (4) 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.

**HCBS Waivers:** ID/LAH

**Key Terms:**
Supported Employment Small Group

**Procedures**: Supported Employment Small Group must be provided in a manner that promotes integration into the workplace and interaction between participants and individuals 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 1:2-3 or 1:4 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.

## A.9.4 TRANSPORTATION

**Responsible Office:** Offices of Employment Services
**Reference:** ADMH Administrative Code; Medicaid Administrative Code
**Effective:** Historical Practice

**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.

**HSBC Waivers:** ID/LAH

**Key Terms:**
Employment Transportation

**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.

## A.9.5 BENEFITS PLANNING AND REPORTING

**Responsible Office:** Offices of Employment Services
**Reference:** ADMH Administrative Code 580-5-30; Medicaid Administrative Code
Effective: Historical Practice

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

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

**HCBS Waivers:** ID/LAH

**Key Terms:**
Benefits Planning and Reporting

**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) or by the provider agency.

1. The Alabama Department of Mental Health provides Social Security Benefits Planning and Reporting services in all 5 DD regions. This service is provided by 5 benefit specialists [3 Community Work Incentive Coordinators (CWICS) and 2 Community Partner Work Incentive Coordinators (CPWICs)]. Referrals are accepted from any Alabama provider/agency. This service is provided by 4 Community Work Incentive Coordinators (CWICs). Self-referrals or partner referrals can be made on a beneficiary's behalf. To request CWIC services, please email: maryjane.dasher@mh.alabama.gov or contact
   256-366-7612. (Necessary records will be obtained, including releases, and forwarded on to the appropriate CWIC).

2. Provider agencies may offer these services directly and receive waiver reimbursement if:
   a. For benefits planning, the agency must employ a credentialed staff member. This credentialing requires completion of either a national recognized 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)
   b. 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 overview, provided by an ADMH - CWIC. An ADMH Employment Specialist can arrange this training session or provider can reach out directly to: Maryjane.dasher@mh.alabama.gov or 256-366-7612. 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 at** www.ssa.gov/disabilityresearch/workincentives.htm and www.ssa.gov/redbook
4. The agency requesting a benefit reporting service should provide copies of individual's check stubs to 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.

# CHAPTER 10
# SELF-DIRECTED SERVICES

## A.10.1 SELF-DIRECTED SERVICES HANDBOOK

**Responsible Office:** Offices of Support Coordination
**Effective:** November 1, 2020

**Statement:** The term "self-direction" refers to a service delivery option in which the individual who receives waiver services decides how, when, and from whom those services will be delivered. Self-direction is designed to make service delivery as flexible as possible for individuals and their families, and to make sure individuals who self-direct can exercise maximum choice and control over their services and supports.

**Purpose/Intent:** The Self-Directed Services Handbook is designed to provide information to participants, representatives, family members, support coordinators, and Self-Directed Liaisons about self-directed services available through the Alabama Intellectual Disabilities and Living at Home Waiver for Persons with Intellectual Disabilities (ID/LAH Waiver).

Self-direction comes with many benefits, and it also comes with responsibilities. This handbook is designed to be a detailed resource about the self-directed services offered through Alabama's Intellectual Disabilities and Living at Home Waiver.

This handbook can help individuals who are new to the Intellectual Disabilities and Living at Home Waiver or to self-directed services learn more about how the self-directed model works—and how to make self-direction work best for them!

**HCBS Waivers:** ID/LAH

**Procedures:** Refer to Self-Directed Services Handbook

**Please click the link below to access the SELF-DIRECTED SERVICES HANDBOOK:**

**SELF-DIRECTED SERVICES HANDBOOK**
https://mh.alabama.gov/wp-content/uploads/2025/05/Self-Directed-Services-Handbook.pdf

## A.10.2 REFERRAL TO SELF-DIRECTED SERVICES

**Responsible Office:** Offices of Support Coordination
**Reference:** ADMH/DDD Operational Procedures
**Effective:** November 1, 2020

**Purpose/Intent:** Provide the process to refer individuals to be considered for self-directed services option.

**HCBS Waivers: ID/LAH**

**Key Terms:**
SDS (Self-Directed Services)
SDL (Self-Directed Liaison)
Request for Action (RFA)
Alabama Developmental Intellectual Deficits Information System (ADIDIS)
Financial Management System Agency (FMSA)
Employer of Record (EOR)
Employer Identification Number (EIN)

**Procedures:** All requests to enroll an individual into the Self-Directed Services option must be completed and submitted by the Support Coordinator to the Regional Office via the Request for Action (RFA) process. The Support Coordinator should attach self-directed services referral form with the RFA forms when submitting to the appropriate regional office.

**PROCEDURES FOR SUPPORT COORDINATOR**

1. Hold a meeting with the individual and/or his/her family to explain the service delivery option of self-directed services.
2. Provide the individual and/or family member with a copy of the SDS Handbook and answer questions detailing the difference between the self-directed service option and traditional service delivery option.
3. If individual and/or family indicate an interest in the self-directed services option, then the Support Coordinator must complete the entire SDS Referral form and RFA form.
4. Submit the completed SDS Referral form (Revised 6/2/2020) and RFA form to the appropriate regional office via the RFA process outlined in Operational Guideline A.4.2. When the RFA is submitted in ADIDIS the Support Coordinator should tag the CSD, waiver coordinator and SDL.

**PROCEDURES FOR SELF-DIRECTED LIAISON**

1. After the RFA Committee in the Regional Office renders a decision, then the Self-Directed Liaison will contact the individual.
2. If the RFA for SDS Referral is approved, then the SDL will contact the individual/family member to provide self-directed services application packet and schedule a meeting to discuss the SDS information.
3. This SDS approval is for enrollment into the SDS delivery option. The individual cannot begin to employ individuals until he/she has received a hire date from the FMSA. Services performed prior to the hire date will not be reimbursed by waiver funds.
4. Submit information to the Financial Management System Agency for review.

**PROCEDURES FOR FINANCIAL MANAGEMENT SERVICES AGENCY**

1. Receive documents submitted
2. Process documents and determine if individual/family can obtain an employer identification number (EIN) and become an employer of record (EOR).
3. Process employee application and background checks for potential employees.
4. If there are problems with the application or it is incomplete, this will delay the process. The FMSA will send an email to the SDL or EOR to request additional information.
5. Once the EOR has been approved, then they receive notification of their EIN number.
6. Once the employee is approved to work, then the FFMSA will send an email with the employee hire date.

## A.10.3 PURCHASE OF GOODS, EAA, SME, SMS, PERS

**Responsible Office:** Offices of Support Coordination
**Reference:** ADMH/DDD Operational Procedures
**Effective:** November 1, 2020

**Purpose/Intent:** Provide the process to obtain and be reimbursed for specialized medical equipment, specialized medical supplies, environmental accessibility adaptations, personal emergency response system and other goods.

**HCBS Waivers:** ID/LAH

**Key Terms:**
Specialized Medical Equipment (SME)
Specialized Medical Supplies (SMS)
Environmental Accessibility Adaptations (EAA)
Personal Emergency Response System (PERS)

**Procedures:**

**Procedures for Employer of Record:**

1. Prior to making a purchase the individual/employer of record (EOR) should submit the request to use waiver funds for purchases to his/her Support Coordinator
2. The EOR should review his/her budgetary savings report to determine if the funds are available for the purchase of goods
3. The request should provide explicit details about the reason for the purchase and how it will benefit the waiver recipient.
4. The request should include three quotes for the items being purchased with the exception of specialized medical supplies.

**Procedures for Support Coordinator:**

1. The Support Coordinator should review the person-centered plan and plan of care to ensure that the requested good or service is identified.
2. The Support Coordinator should review the monthly utilization report (budgetary savings report) to ascertain if the individual has the funds available for purchase.
3. The RFA should include a detailed explanation of reason for purchase, most recent copy of budgetary savings report, three quotes for the item, completed prior approval form (revised 10/19/2020) and ensure the purchase aligns with waiver stipulations and person-centered plan for the service or goods.
4. The Support Coordinator must submit the request to the regional office via the Request for action (RFA) process (see OG A.4.2) in ADIDIS and tag the CSD, waiver coordinator and self-directed liaison.

**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 and person-centered plan
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. Inform the self-directed liaison of the decision

**Procedures of Support Coordinator after Regional Office Review:**

1. Inform the waiver recipient/employer of record of the Regional Office decision or request for additional information
2. If additional information is required by Regional Office, then request the additional information be provided by the EOR.
3. Submit additional information to the regional office.

**Procedures for waiver recipient/employer of record to purchase items after receiving approval:**

The EOR has two options to obtain items

1. Pay the provider directly for items and submit receipts to their Support Coordinator for reimbursement –OR--
2. Have the supply vendor send a W-9 form to financial management service agency (FMSA) so that FMSA can pay the supply vendor directly. In this scenario, receipts should also be sent to the support coordinator to keep with the person's records.

**Procedure for Support Coordinator after EOR submits receipts:**

1. Email or fax the previously approved Prior Approval form and receipts to financial management service agency.
2. Retain a copy of the Prior Approval form and receipts with the person's records

## A.10.4 MONEY MANAGEMENT FOR INDIVIDUALS SERVED *(Removed)*

# LIST OF FORMS TABLE FOR ID/LAH WAIVERS

| Form Reference | Form Title/Links |
|---|---|
| **Operational Guideline A.1.1** | **INITIAL CONTACT INFORMATION FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Initial-Contact-Information-Form.pdf |
| **Operational Guideline A.1.6. e.** | **ADMH REQUEST FOR PLACEMENT & INSTRUCTIONS FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/ADMH-Request-for-Placement-and-Instructions.pdf |
| **Operational Guideline A.2.1** | **NOTICE OF APPEAL ADVERSE ACTION FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Notice-of-Appeal-Adverse-Action.pdf |
| **Operational Guideline A.2.1** | **DISSATISFACTION OF SERVICES GRIEVANCE FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Dissatisfaction-of-Services-Grievance-Form.pdf |
| **Operational Guideline A.4.2** | **REQUEST FOR REGIONAL ACTION & INSTRUCTIONS FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Request-for-Regional-Action-and-Instructions.pdf |
| **Operational Guideline A.4.3** | **ANNUAL PHYSICALEXAMINATION FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Physical-Examination-Form.pdf |
| **Operational Guideline A.4.5** | **INDIVIDUAL EXPERIENCE ASSESSMENT SURVEY FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Individual-Experience-Assessment-Survey.pdf |
| **Operational Guideline A.4.8 & A.5.10** | **ANNUAL FINANCIAL ASSESSMENT FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Financial-Assessment.pdf |
| **Operational Guideline A.4.9** | **FREEDOM OF CHOICE FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Freedom-of-Choice-Form.pdf |
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|---|---|
| **Operational Guideline A.4.8 & A.5.10** | **ANNUAL FUNCTIONAL ASSESSMENT FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Functional-Assessment-Form.pdf |
| **Operational Guideline A.4.8 & A.5.10** | **RIGHTS ASSESSMENT FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Rights-Assessment.pdf |
| **Operational Guideline A.4.8 & A.5.10** | **ANNUAL SAFETY ASSESSMENT FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Safety-Assessment.pdf |
| **Operational Guideline A.5.1** | **APPLICATION AND SETTING REVIEW FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Application-and-Setting-Review-Form.pdf |
| **Operational Guideline A.5.10** | **PCP TIMELINE FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/PCP-Timeline.pdf |
| **Operational Guideline A.5.11** | **RENT RESIDENCY GUIDE FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Rent-Residency-Guide-Form.pdf |
| **Operational Guideline A.6.1** | **FACTORS AND INDICATORS CHART FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Factors-and-Indicators-Chart.pdf |
| **Operational Guideline A.7.1, A.7.2 & A.7.3** | **ADMH – DDD BEHAVIOR SUPPORT PLAN CHECKLIST FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/ADMH-DDD-Behavior-Support-Plan-Checklist.pdf |
| **Operational Guideline A.7.6.a** | **ADMH – DDD CRISIS INPATIENT REFERRAL FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/ADMH-DDD-Crisis-Inpatient-Referral-Form.pdf |
| **Operational Guideline A.10.1** | **SELF-DIRECTED SERVICES HANDBOOK**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Self-Directed-Services-Handbook.pdf |

# SECTION B
# COMMUNITY WAIVER PROGRAM (CWP)

# CHAPTER 1
# ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

## B.1.1 INTAKE INFORMATION/REFERRAL

**Responsible Office**: Offices of Support Coordination
**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
**Effective**: December 1, 2021
**Revised:** March 22, 2022

**Reviewed**: January 5, 2025

**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 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 requests must come to the CC. Regardless of the location of the caller, the county in which the legal guardian or the person resides will dictate the regional office and support coordination agency (SCA) to which the referral will be sent.

**HCBS Waivers**: ID, LAH, CWP

**Key Terms**:
Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DD)
Call Center (CC)
Home and Community Based Services (HCBS)
Support Coordination Agency (SCA)
Support Coordinator (SC)
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 application for waiting list to any caller.
6. The CC staff will process applications for all requests for services regardless of whether they meet criteria for wait list eligibility, send the application to the appropriate SCA, and also refer the applicant or their representative to other applicable state or community services.
7. When there is more than one support coordination provider in the county, the individual will be provided choice of provider.
8. Please note only CWP Waiver services are available in the following 11 counties: Madison, Morgan, Limestone, Tuscaloosa, Jefferson, Elmore, Montgomery, Baldwin, Mobile, Houston, Walker. ID and LAH waiver participants in those counties will continue to receive services as usual through those waivers.
9. The designated support coordination agency for each county/area serves as the point of entry for waiver applications. The designated support coordination agency collects necessary documentation and files the application with the Regional Community Services offices. The Regional Community Services offices process all complete Waiting List applications to determine eligibility and placement on the waiting list. Once determined eligible for the waiting list, subsequent enrollment in one of the waivers depends on criticality of need, availability of resources, and space within the waiver caps on the number who can be served.
10. Once the application is received by the SCA from the ADMH-DD CC, the intake person should contact the individual or their representative immediately; but no later than 5 business days.
11. 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.
12. 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 waiting list coordinator requesting a follow-up.
13. 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.
14. Once contact with the individual seeking services has been established, the SCA will submit the completed information packet for review to the Regional Community Services 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 decision of eligibility within 30 days of the receipt of the completed application.
    a. **Exceptional Circumstances: If an individual or their family member has difficulty with communication via the phone, arrangements can be made with the Regional Community Services office to set up a face-to- face meeting.

b. ***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.

**Please click the link below to access form:**

**INITIAL CONTACT INFROMATION FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Initial-Contact-Information-Form-CWP.pdf

## B.1.2 WAITING LIST

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

**Responsible Office**: Offices of Community Programs, Offices of Support Coordination
**Reference**: Chapter 580-5-30-.13 Eligibility and Level of Care Determinations for Medicaid HCBS Programs, Alabama Department of Mental Health Division of Developmental Disabilities Administrative Code
**Revised**: August 7, 2023

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

**Purpose/Intent**: The process for determining eligibility for HCBS services and being placed on the Waiting List involves specific, crucial steps governed by detailed standards and practices of communication between the Regional Community Services (RCS) Waiting List Coordinator and the referring 310 agencies.

**HCBS Waivers**: CWP

**Key Terms:**
Alabama Department of Intellectual Disabilities Information Management System (DDD IMS)
Inventory for Client and Agency Planning (ICAP)

**Procedures:**
1. The person seeking Waiver services (or their caregiver) contacts the Call Center to initiate application.
2. The Support Coordination Agency:
   a. Gathers information from the applicant and/or caregivers in order to accurately complete the Criticality Assessment (reference ADMH-DDD OG 1.4) and the ICAP (reference ADMH-DDD OG 1.3);
   b. Assists the applicant and/or caregivers with gathering documents needed to substantiate eligibility as described in 4.a-c;
   c. Uploads the eligibility documentation to the DDD IMS and tags the RCS Waiting List Coordinator to notify them of its availability.

3. In order for the applicant to be deemed eligible for placement on the Waiting List, the submitted eligibility documentation must demonstrate the following for 1915c services:
   a. The applicant evidences significant problems in at least three adaptive functioning areas (Self-Care, Receptive & Expressive Language, Mobility, Self-Direction, Capacity for Independent Living, and Learning) as demonstrated through:

      - Administration of an ICAP to include an ICAP Compuscore report, with corresponding information entered into the ADIDIS Eligibility Assessment, which uses an algorithm to populate the adaptive functioning problem categories.
      - The Diagnosis Record in ADIDIS (for Learning area)

   b. The applicant achieved a full-scale IQ score below 70, evidencing the presence of an intellectual disability, documented before the age of eighteen.
      - For children, the IQ evaluation must be within three years prior to date of waiver application.
      - For adults ages 18 and older, an IQ evaluation done prior to age 18 and showing a score of below 70 is required, as well as a second IQ evaluation done after the individual turned 18 years of age.
      - If more than one IQ evaluation exists and was done prior to age eighteen, the most recent evaluation administered will be the score considered valid unless there is a significant variation in IQ score as compared to older evaluation(s), and one or more of the scores is 70 or above. In this situation, the evaluations will undergo additional review by the Eligibility Review Committee to determine if 5.c. may apply.

   c. The primary cause(s) of impaired functioning and/or the full-scale IQ below 70 is not the result of mental illness, a developmental disability, epilepsy or traumatic brain injury acquired after age 18, or external factors such as medication, substance use effects, or stress.

## B.1.2.b Wait List Selection *(Removed)*

## B.1.2.c Community Waiver Program Enrollment from Wait List

**Responsible Office:** Offices of Support Coordinator Services, ADMH-DDD Central/Regional Offices
**References:** ADMH-DDD OG 1.2.; Flowchart
**Effective:** December 17, 2021
**Revised:** February 20, 2025

**Statement:** Persons on the Waiting List are identified, via prioritized criteria, to be enrolled in the Community Waiver Program.

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

**HCBS Waivers:** CWP

**Key Terms:**

Interchange
Person-Centered Plan (PCP)

**Procedures:**

1. The Waiting List Coordinator:
   a. Verifies statutory (reference ADMH-DDD OG 1.2) and Medicaid eligibility for each person identified who met priority criteria and elected to receive Community Waiver services and uploads a scan of the corresponding Interchange Screen to the DDD IMS;
   b. If eligibility information is not current and/or available:
      - the Wait List Coordinator will tag the 310 to provide missing and outdated information to include verification of contact information for the applicant.
      - The 310 will have 60-days to provide additional eligibility information needed and notify the Wait List Coordinator as soon as the information is uploaded into ADIDIS.
   c. If eligibility is determined, the RO Waiting List Coordinator contacts each person in their assigned Region who is identified in this sorting of the Waiting List in order based on how long they have been on the Waiting List. The WLC informs the individual of the opportunity to participate in the Community Waiver program and determines if upon their report, they meet any of the following priority criteria (in descending order or priority):
      - They require services to preserve their current living arrangement (e.g., not seeking Residential services) and have a goal to obtain integrated, competitive employment or currently have integrated, competitive employment and require supports to maintain it. Additionally, they confirm they wish to begin receiving services to address these needs and goals immediately as opposed to at some future point.
      - They require services to preserve their current living arrangement (e.g., not seeking Residential services) and they confirm they wish to begin receiving services to address these needs and goals immediately as opposed to at some future point.
      - They have a goal to obtain integrated, competitive employment or currently have integrated, competitive employment and require supports to maintain it.

   d. Informs the person, if they meet none of these priority criteria, that they will be contacted again if Community Waiver slots remain after those meeting the priority criteria and accepting services are served. Additionally, they confirm they wish to begin receiving services to address these needs and goals immediately as opposed to at some future point.
   e. If a person chooses not to enroll in the Community Waiver Program, their Waiting List status is updated to reflect that they declined services. The individual/family receives information for steps forward should their decision change.
   f. If an individual that initially declined services reconsiders the Community Waiver Program, their Waiting List status will be updated at the point of contact.
   g. If the individual chooses to enroll, the Wait List Coordinator updates their status indicating acceptance of waiver enrollment. The Wait List Coordinator then refers the applicant to the CWP Director via the DDD IMS and email for approval of an allocated waiver slot for their appropriate enrollment group.

h. Once the Wait List Coordinator is informed of the CWP Director's decision to enroll or deny, the Wait List Coordinator then forwards the individual approved for an allocated slot to the Waiver Coordinator.

2. If eligibility is determined and an allocated slot is available except for financial requirements:
   a. In the case of an individual needing to request a 300% Waiver Slot due to income and/or resources exceeding the approved monthly cap ($2000), the 310 Board is responsible for assisting the individual with completing the Alabama Medicaid Form 204/205.
   b. The 310 Board will request and obtain a completed Alabama Medicaid Form 376 from the RO Waiver Coordinator.
   c. The 310 Board will directly submit both Alabama Medicaid Forms 204/205 and Form 376 to the appropriate District Alabama Medicaid office for approval or denial.
   d. If Alabama Medicaid denies the individual information, the 310 will continue to assist the family until approval is granted. If Alabama Medicaid approves the 204/205 application, a 300% Waiver Slot is allocated for further enrollment into the CWP. Alabama Medicaid will notify the Sponsor and the RO Waiver Coordinator of approval or denial.
   e. The RO Coordinator will notify the SCA of final decision on enrollment.
3. The Regional Office Waiver Coordinator:
   a. Once approval or denial is received from Central Office Waiver Coordinator, the RO Waiver Coordinator communicates with the appropriate Support Coordinator Agency via DDD IMS (ADIDIS) of the decision.
   b. The RO Waiver Coordinator will send a formal written notification to the individual and attach the communication in ADIDIS.
4. The Regional Fiscal Manager:
   a. Authorizes, via the DDD IMS, the person enrolled for the Support Coordination service.
5. The Central Office Waiver Coordinator:
   a. Forwards the RO Waiver Registration (See attached) and Interchange Screen to Alabama Medicaid for approval.
   b. The Central Office Waiver Coordinator notifies the Regional Office Waiver Coordinator of the approval/denial.
   c. The Central Office Waiver Coordinator also notifies the CWP Support Coordinator Supervisor who assigns a Support Coordinator.
6. The Support Coordinator:
   a. Meets with the person seeking enrollment in Community Waiver program (within ten (10) business days of referral);
   b. Identifies person's unique goals and outcomes, and the person's needs related to achieving these goals and outcomes. Identifies specific Community Waiver services that can meet the needs identified and related to the person's defined goals and outcomes. Determine amount, duration and frequency of each Community Waiver service needed by the person;
   c. Reviews providers available in the area where the person lives who are available to provide each of the specific Community Waiver services. Assists the person to decide, for each service, which providers the person wishes to consider and obtains signed releases from the person to contact those providers on the person's behalf.

d. Develops referrals for the Community Waiver services for the person and sends those to the providers the person wishes to consider. Ensures a response from each provider is received and informs the person about which providers indicated interest in serving the person;
e. Coordinates choice meetings/tours (as applicable) between the person and providers being considered by the person and who expressed interest in serving the person;
f. Ensures a willing provider of service, acceptable to the person, is identified for each Community Waiver service.
g. Develops an initial Person-Centered Plan( within 60 days) reflecting the person's unique goals and outcomes, Community Waiver services needed to achieve those goals and outcomes, and the providers selected by the person. The PCP will also include all information as required by federal regulations (42 CFR § 441.540 and 441.725) and state regulations; and,
h. Notifies the Regional Waiver Coordinator of the completion of the initial Person-Centered Plan in the DDD IMS.

## B.1.3 ENROLLMENT

### B.1.3.a Group 4 Non-Reserve Capacity Enrollment Criteria and Procedure

**Responsible Office:** Community Waiver Program
**Reference:** ADMH-DDD OGs #1.1; 1.2.a; CWP RFA
**Effective:** December 7, 2021
**Revised:** March 22, 2022
**Reviewed:** January 5, 2025

**Statement:** During each Community Waiver Program (CWP) demonstration year, slots that are not needed for reserve capacity may be available in enrollment Group #4 for individuals on the waiting list who meet institutional level of care and have an assessed need for the services available in Group #4.

**Purpose/Intent:** In the CWP, the 1915c enrollment Group #4 has slots set aside for CWP enrollees meeting institutional level of care whose assessed needs cannot be met through the services available in the enrollment group they would otherwise be eligible for based on age. For individuals ages 3-13, this would be Group #1. For individuals ages 14-21, this would be Group #2. For individuals ages 22+, this would be Group #3.

A preference for the services available in Group #4 does not make a CWP enrollee eligible for Group #4. Beyond preference, the CWP enrollee must have assessed needs that cannot be safely and appropriately met in the enrollment group they would otherwise be eligible for based on age. Per policy, no individual shall be enrolled in 1915c Group #4 unless it has first been established that their outcomes and related needs cannot be safely and appropriately addressed in one of the other CWP enrollment group for which they are eligible based on age.

This Operational Guideline addresses the enrollment criteria and procedures for Group #4 enrollments. This ensures the CWP programs goals of preserving and supporting the least restrictive, most integrated, and most cost-effective living arrangements, keeping families together, and maximizing individuals' independence, are met.

**HCBS Waivers:** CWP

**Key Terms:**
Community Waiver Program (CWP)
Division of Developmental Disabilities (DDD)
PCP (Person Centered Plan)
Request for Action (RFA)
Community Waiver Program/Special Review Committee (CWP/SRC)

**Procedures:**
Individuals on the Waiting List that meet institutional level of care, and therefore qualify for the CWP 1915c Waiver, but do not qualify for a reserve capacity slot, shall always be initially enrolled in the enrollment group they would otherwise be eligible for based on age. For individuals ages 3-13, this would be Group #1. For individuals ages 14-21, this would be Group #2. For individuals ages 22+, this would be Group #3.
The assigned CWP Support Coordinator shall engage with the individual (and legal guardian if applicable) and other involved family/natural supports as identified by the person to be involved. The CWP Support Coordinator shall complete the comprehensive assessment process that precedes Person-Centered Planning and then shall use the information obtained through the comprehensive assessment process in facilitating a Person-Centered Planning process that identifies the individual's desired outcomes and related service & support needs in each domain area addressed in Person-Centered Plan.

As part of the Person-Centered Planning process, the service and support needs identified will be addressed by identifying effective strategies in the following order:
1. The person's own skills, abilities, and resources
2. Natural supports already involved in the person's life
3. Community resources available to the person outside of CWP waiver services and other non-CWP public programs (Note: Non-CWP public programs include E.g., ADRS; Special Education/school system; Medicaid State Plan; etc.)
4. Services available to the person through other non-CWP public programs (E.g., ADRS; Special Education/school system; Medicaid State Plan; etc.)
5. Services and/or supports available through the CWP waiver that can complement and sustain the other available strategies in categories 1 through 4 above.

In identifying any needed services and support available through the CWP waiver, the full range of services available in the individual's existing enrollment group shall be considered. The possibility of receiving approval to exceed individual service limits and/or exceed the enrollment group expenditure cap, in order to prevent the need for Group #4 enrollment shall also be considered if such approvals may be needed to prevent the need for Group #4 enrollment.

If a Person-Centered Plan can be developed for the individual that enables the person to be safely and effectively served in their existing enrollment group, with or without approval to exceed one or more individual service limits and/or to exceed the expenditure cap, the CWP Support Coordinator will proceed with seeking approval for that Person-Centered Plan, including utilizing the RFA process if approval is needed to exceed individual service limits and/or exceed the enrollment group expenditure cap, in order to prevent the need for Group #4 enrollment.

If a Person-Centered Plan cannot be developed for the individual that enables the person to be safely and effectively served in their existing enrollment group, with or without approval to exceed one or more

individual service limits and/or to exceed the expenditure cap, the CWP Support Coordinator will proceed with seeking approval for transition to Group #4 via the RFA process [See: CWP OG B.3.3 Request for Regional Action (RFA)]

The Support Coordinator shall submit to the Support Coordinator Supervisor for the Region where the individual resides, the RFA and supporting documentation. Per RFA instructions, justification is required, and documentation should fully describe the individual's need. Therefore, supporting documentation for request for transition to Group #4 shall include the following:

1. A copy of current ICAP tool (updated in the last 12 months and more recently if needed to reflect changes in condition supporting the request for Group #4 enrollment)
2. Information listing the location in ADIDIS of all information together constituting an up-to-date comprehensive assessment for the individual and submission of any other information not stored in ADIDIS, if applicable.
3. Confirmation the Person-Centered Plan - that was developed, per the above-described process and that must precede any RFA for Group #4 enrollment - is fully documented in ADIDIS and submission of any other information relevant to this Person-Centered Plan that is not housed in ADIDIS, if applicable.
4. Confirmation that the individual's current contact information (and current contact information for legal guardian and any other members of the Person-Centered Planning team, as applicable) is accurate in ADIDIS.
5. Additional concise written justification by the Support Coordinator.

The CWP Support Coordinator Supervisor (and/or designee as identified by the CWP Director) shall fully review all of the information as noted in 1 through 5 immediately above. The Supervisor (and/or designee as identified by the CWP Director) shall then meet in-person with the individual (and legal guardian, if applicable), and meet in-person or virtually with involved natural support(s), other potential natural supports identified, and any other relevant persons or professionals to fully evaluate the person's situation, obtain and/or verify information relative to the individual's needs.
The Supervisor (and/or designee as identified by the CWP Director) shall, through the review, determine the least restrictive, most integrated living situation that can be supported for the person through CWP services. The CWP Support Coordinator Supervisor (and/or designee as identified by the CWP Director) shall do this by following this decision-making strategy:

1. Preserving a natural living arrangement (existing or if not possible, with an alternative natural caregiver) will be the first priority. Where the existing natural living arrangement cannot or should not continue, sufficient efforts must be made to identify an alternative natural caregiver and living arrangement that could, with the addition of CWP services, be feasible for the individual. Where an existing or new natural living arrangement can be supported, the individual will remain enrolled in their existing enrollment group. The Person-Centered Plan will be revised to **allow CWP services are utilized to wrap-around and support the identified natural caregiver and living arrangement.** If an RFA is needed to exceed a particular service limit and/or exceed the expenditure cap for this enrollment group, the Support Coordinator will prepare and submit the RFA.

   If supporting the person in an existing or new natural living arrangement is determined, by the Supervisor (and/or designee as identified by the CWP Director), to not be possible, the efforts undertaken to do this must be documented to demonstrate that sufficient efforts were made before consideration moves to 2. described next.

2. When an existing natural living arrangement cannot or should not be continued, and an alternative/new natural living arrangement cannot be identified, facilitating the least restrictive, most integrated living arrangement will be the second priority.
   In these cases, where a person is age 18-21, they will be assessed for capacity to live independently (with CWP services available in Group #2). Where a person is age 22+, they will be assessed for capacity to live independently (with CWP services available in Group #3) or in a non-intensive Supported Living arrangement (with CWP services available in Group #3). If any of these options are possible, within the existing enrollment group and expenditure cap, or with approval to exceed the expenditure cap via RFA, the person will remain enrolled in their existing enrollment group. The Person-Centered Plan will be revised accordingly and if an RFA is needed to exceed a particular service limit and/or exceed the expenditure cap for this enrollment group, the Support Coordinator will prepare and submit the RFA.

   If persons are under age 18 or assessment/efforts by the Support Coordinator, Supervisor (and/or designee as identified by the CWP Director) demonstrates the person does not have capacity to live independently (with CWP services available in Group #2 or #3, based on age) and, if age 22+, they also do not have capacity to live in a non-intensive Supported Living arrangement (with CWP services available in Group #3), the efforts undertaken to do this must be documented to demonstrate that sufficient efforts were made before consideration moves to 3. described next.
3. The CWP Support Coordinator Supervisor (and/or designee as identified by the CWP Director) shall compile all information and documentation supporting the need for Group #4 enrollment, including documentation evidencing how the above decision-making strategy was followed to arrive at the conclusion that Group #4 enrollment is needed. The CWP Support Coordinator Supervisor (and/or designee as identified by the CWP Director) shall forward all of this information to the CWP/Special Review Committee for review and enrollment decision.

The CWP/Special Review Committee shall be comprised of the CWP Director, DDD Director of Community Programs and DDD Director of Fiscal Services. DDD Director of Psychological and Behavioral Services and/or ADMH Director of Nurse Delegation Program shall also serve as ad hoc members on the team dependent upon the special needs of the individual.

a. Within seven (7) business days of receipt of the information, the CWP/SRC shall meet and determine if the information/documentation submitted fully supports enrollment into Group #4.

Specifically, the CWP/SRC shall:

- Approve or deny enrollment using the Group #4 Needs Verification Scoring Tool attached.
- If approved, the respective CWP Support Coordinator Supervisor and Support Coordinator shall be notified, and the Waiver Coordinator shall be instructed to proceed with the transition of the individual to Group #4.
- If denied, the respective CWP Support Coordinator Supervisor and Support Coordinator shall be notified, and a determination letter and Notice of Appeal is sent to the individual.

### B.1.3.b Reserve Capacity Enrollment Criteria and Procedure

**Responsible Office:** Community Waiver Program
**Reference:** ADMH-DDD OGs #1.1, 1.2.a., and 3.1; CWP RFA
**Effective:** December 7, 2021
**Revised:** March 22, 2022

**Reviewed:** January 5, 2025

**Statement:** Reserved capacity slots are available in the Community Waiver Program (CWP) for individuals on the waiting list who meet institutional level of care and other specific criteria evidencing emergent circumstances.

**Purpose/Intent:** In the Community Waiver Program (CWP), the 1915c enrollment group #4 has slots set aside for reserve capacity as defined and approved in the federal waivers. However, in some cases, an individual on the waiting list, who meets institutional level of care and other specific criteria evidencing emergent circumstances, may be able to be safely and appropriately served in one of the other 1915c enrollment groups. [Example: an adult that becomes homeless, but who can successfully live in a non-intensive Supported Living arrangement, would be most appropriately enrolled in 1915c Group #3] Per the approved federal waivers, ADMH-DDD has the ability to move slots between enrollment groups to meet needs and this includes the ability to move reserve capacity slots when appropriate.

Per policy, no individual shall be enrolled in 1915c Group #4 unless it has first been established that their outcomes and related needs cannot be safely and appropriately addressed in one of the other CWP enrollment group for which they are eligible based on age.

This Operational Guideline addresses the use of reserve capacity slots and the process for ensuring enrollment of individuals who require a reserve capacity slot into the appropriate enrollment group.

**HCBS Waivers:** CWP

**Key Terms:**
Community Waiver Program (CWP)
Division of Developmental Disabilities (DDD)
Person Centered Plan (PCP)
Request for Action (RFA)
Community Waiver Program/Special Review Team (CWP/SRT)
Reserved Capacity Slots

**Procedures:**
All individuals referred to ADMH-DDD for waiver services must be processed through the Call Center and determined eligible for the Waiting List.

Individuals on the Waiting List whose current situation suggests they may need a reserve capacity slot should be referred to the CWP Support Coordinator Supervisor in the Region of the individual's residence.

The CWP Support Coordinator Supervisor shall meet with the individual to evaluate the person's situation and obtain and/or verify the following information relative to the individual's special need for a reserve capacity slot:

a. Age 3 years+

b. Eligible for 1915c waiver (ID; institutional level of care)

c. Financially eligible for the CWP

d. Has emergent circumstances that makes the individual eligible for one or more of the reserved capacity categories. Emergent circumstances include:

- Outplacement from Nursing Home or Other Institutional Setting: Enrollment in the CWP is necessary to facilitate transition out of a long-term care facility, i.e., nursing home, ICF/IID or in-patient mental health facility into a more community integrated setting.
- Transition from LAH Waiver: Enrollment in the CWP is necessary to facilitate transition of an LAH Waiver participant, residing in a CWP county, whose outcomes and needs can no longer be safely and appropriately addressed in the LAH Waiver.
- Children in State Care/Custody: Enrollment in the CWP is necessary to facilitate needed services for a child aging out of the state foster care system or children in foster care not yet aging out but experiencing a prolonged crisis which the foster care system is unable to address without assistance in the form of CWP services.
- Emergencies: Enrollment in the CWP is necessary to address an individual who would otherwise be homeless or subject to abuse and/or neglect or be in significant danger of harm to self or others and thus requiring immediate access to services. This includes:
    - The individual's primary caregiver is deceased, incapacitated or otherwise unavailable and there is no other caregiver available to provide needed supports without the availability of CWP services. This includes situations where homelessness results from the loss of a primary caregiver who provided a home for the person in addition to needed supports.
    - There is clear evidence of serious abuse, neglect, exploitation in the current living arrangement, the individual must move from this arrangement to prevent further abuse, neglect or exploitation, and there is no other appropriate. living arrangement available without the availability of CWP services.
    - The health, safety or welfare of the individual is in immediate and ongoing risk of serious harm or danger. Other interventions including behavioral health crisis prevention, intervention, and stabilization services, where applicable, have been exhausted and proven unsuccessful in minimizing the risk of serious harm to the individual or others.
    - The individual has multiple complex chronic or acquired health conditions that natural caregivers cannot manage without the availability of CWP services; and the individual is in urgent need of CWP services and supports in order to maintain their current living arrangement and delay or prevent the need for more restrictive, less integrated, and more costly services and supports.

If the CWP Support Coordinator Supervisor determines the person is eligible for the CWP 1915c waiver and a reserve capacity slot, the CWP Support Coordination Supervisor shall do additional investigation of the person's circumstances and additional assessment to determine the least restrictive, most integrated living situation that can be supported for the person through CWP services. The CWP Support Coordination Supervisor shall do this by following this decision-making strategy:

1. Preserving a natural living arrangement (existing or if not possible, with an alternative natural caregiver) will be the first priority. In these cases, the individual is enrolled in a reserve capacity slot allocated to Group #1, #2 or #3 based on age of the individual. **CWP services are utilized to wrap-around and support the natural caregiver and living arrangement.** Where the existing natural living arrangement cannot or should not continue, sufficient efforts must be made to identify an alternative natural caregiver and living arrangement that could, with the addition of CWP services, be feasible for the individual. These efforts must be documented to demonstrate that sufficient efforts were made before consideration of residential placement through Group #4 enrollment.
2. When an existing natural living arrangement cannot or should not be continued, or is not available (E.g., homelessness; aging out of foster care system; leaving an institutional setting; etc.), facilitating the least restrictive, most integrated living arrangement will be the second priority.

   In these cases, where a person is age 18-21, they will be assessed for capacity to live independently (with CWP services available in Group #2). Where a person is age 22+, they will be assessed for capacity to **live independently (with CWP services available in Group #3) or in a non-intensive Supported Living arrangement (with CWP services available in Group #3).** If any of these options are possible, within the existing Group #2 or Group #3 expenditure cap, or with approval to exceed the expenditure cap via RFA, the person will be enrolled in Group #2 or #3 (based on age) and the reserve capacity slot they are using will be allocated to the group in which they are enrolled.

   If persons are under age 18 or documentation of assessment demonstrates they do not have capacity to live independently (with CWP services available in Group #2 or #3, based on age) and, if age 22+, they also do not have capacity to live in a non-intensive Supported Living arrangement (with CWP services available in Group #3), the person will be enrolled in Group #4 and assigned the appropriate reserve capacity slot in this Group.

The CWP Support Coordinator Supervisor shall compile all information and documentation supporting eligibility for the CWP 1915c waiver, eligibility for a reserve capacity slot, and assessment/documentation evidencing how the above decision-making strategy was followed to arrive at the specific CWP enrollment group being requested. The CWP Support Coordinator Supervisor shall forward all of this information to the CWP/Special Review Team for review and enrollment decision.

1. The CWP/Special Review Team shall be comprised of the CWP Director, DDD Director of Community Programs and DDD Director of Fiscal Services. DDD Director of Psychological and Behavioral Services and/or ADMH Director of Nurse Delegation Program shall also serve as ad hoc members on the team dependent upon the special needs of the individual.

2. Within seven (7) business days of receipt of the information, the CWP/SRT shall meet and determine if the information/documentation submitted fully supports eligibility for the CWP 1915c Waiver, eligibility for a reserve capacity slot, and enrollment into the specific enrollment group requested by the CWP Support Coordinator Supervisor. Specifically, the CWP/SRT shall:

3. Approve, approve with modifications, or deny enrollment in CWP using the attached form.

4. If approved, the respective CWP Support Coordinator Supervisor and Wait List Coordinator shall be notified and instructed to enroll individual.

5. If denied, the respective CWP Support Coordinator Supervisor and Wait List Coordinator shall be notified and instructed to maintain individual on the waiting list.

6. The individual is notified in writing of the decision for services and the written communication is uploaded in ADIDIS.

### B.1.3.c CWP Enrollment Group 4 – Assessment of Exceptional Behavioral or Medical Needs Support Coordination

**Responsible Office:** Assessment of Exceptional Behavioral or Medical Needs
**Reference:** Community Waiver Program 1915(c) Waiver; ICAP Manual
**Effective:** December 14, 2021
**Revised:** March 31, 2022
**Reviewed:** January 5, 2025

**Statement:** Waiver beneficiaries with exceptional behavioral and/or medical needs require greater resources to assist them to achieve maximum independence.

**Purpose/Intent:** Objective assessment of exceptional behavioral and/or medical needs allows for an increased expenditure cap for individuals who qualify for Enrollment Group 4 of the Community Waiver Program (CWP).

**HCBS Waivers:** CWP

**Key Terms:**
Community Waiver Program (CWP)
Inventory for Client & Agency Planning (ICAP)

**Procedures:**
1. The expenditure cap for individuals who qualify for Enrollment Group 4 (Supports to Sustain Community Living) of the Community Waiver Program 1915(c) waiver may increase from $65,000 annually to $100,000 annually in the event that exceptional behavioral and/or medical needs are objectively assessed and substantiated by ADMH DDD.
2. Assessment for exceptional medical or behavioral needs is not done for all CWP enrollees as a routine assessment. This assessment can only be requested after a person-centered planning team meeting and process that results in the possible need for services and supports that would exceed the expenditure cap otherwise available to the CWP enrollee.
3. To substantiate exceptional behavioral needs to qualify for the $100,000 expenditure cap in Enrollment Group 4, the individual's most recent (within one year) ICAP, indicating serious or very serious maladaptive behaviors.
4. To substantiate exceptional medical needs to qualify for the $100,000 expenditure cap in Enrollment Group 4:
   a. The individual's most recent ICAP Service Score (within one year) must be 49 or lower, and

b. The Group #4 Exceptional Medical Needs Assessment will be administered by the appropriate Regional Office's Nurse (see CWP Group #4: Exceptional Medical Assessment).

5. The specific exceptional behavioral/medical needs identified must be included in the PCP, along with specific interventions/supports to address each and monitor their progress, as well as information on how the additional funds are utilized to support the person with regard to the identified exceptional needs.
6. The Support Coordinator should then refer to the RFA process to complete service request.

| **CWP Group #4: Exceptional Medical Assessment Description and Score Range** | Possible Scores:<br>0 (No Support)<br>1 (Monitoring; Occasional Assistance)<br>2 (Extensive; Regular Assistance) |
|---|---|
| **Description of Need** | **Score Range*** |
| Frequent illnesses that interfere with the person's daily routine | **0-2** |
| Seizures - frequent and uncontrolled and/or that required emergency hospitalization within the last year | **0-2** |
| Suctioning | **0-2** |
| Tracheostomy | **0-2** |
| Inhalation or oxygen therapy | **0 - 2** |
| Ventilator | **0-2** |
| Percussion and/or Postural drainage (Chest physiotherapy) | **0-2** |
| Tube feeding; medication administration through tube | **0-2** |
| Oral stimulation or jaw positioning; spoon feeding | **0-2** |
| Parenteral feeding (IV feeding); total parenteral nutrition | **0-2** |
| Incontinence, toileting program and/or bowel care requiring nurse | **0-2** |
| Daily catheterization requiring nurse; suprapubic catheterization; condom catheterization | **0-2** |
| Ostomy Care; Ileostomy Care | **0-2** |
| Person requires lifting for transfer that is difficult for caregiver(s) | **0-2** |
| Orthopedic conditions - scoliosis, hip dysplasia, contractures, etc. | **0-2** |
| Skin breakdowns: Dressing of open wound(s); debriding | **0-2** |
| Turning or positioning to avoid skin breakdowns | **0-2** |
| **Immune system impairment requiring protection from infectious diseases** | **0-2** |
| **Dialysis** | **0-2** |
| **Total Score (Minimum - Maximum)** | **0-38** |
| **Of 19 total assessment elements, minimum that must be scored "2"** | **3** |

### B.1.3.d Community Waiver Program Enrollment Priority When Waiver Capacity is Reached *(Removed)*

## B.1.4 INVENTORY FOR CLIENT AND AGENCY PLANNING (ICAP) FOR COMMUNITY SERVICES

**Responsible Office:** Offices Regional Community Services
**Reference:** Administrative Code 580-5-30.14 Eligibility and Level of Care Determinations for Medicaid Waiver Programs
**Effective:** Historical Practice
**Revised:** April 13, 2023
**Reviewed:** January 5, 2025

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.

**HCBS Waivers:** ID, LAH, CWP

**Key Terms:**
Inventory for Client and Agency Planning (ICAP)
Regional Community Services (RCS)
Comprehensive Support Services (CSS)

Procedures:
1. Prior to administering the ICAP, the Support Coordinator will be trained using an approved training curriculum developed by ADMH.
2. The ICAP is administered by the Support Coordinator as follows:
   a. Must be administered by the SCA upon referral from ADMH of an applicant for the Waiver and must be administered within 90 days of the application being submitted to the RCS office for eligibility determination.
   b. Must be administered every two (2) years at re-determination of eligibility
      - If it is determined that updating the ICAP is not necessary following a review by the Support Coordinator, the Support Coordinator MUST initial and date the ICAP score sheet. This MUST be submitted with the re-determination packet. This should not occur more than 1 time in a 2-year period – this means a new ICAP must be completed every 2 years
   c. Must be administered anytime information regarding the person served changes significantly
3. Administering the ICAP:
   a. The Support Coordinator is responsible for administration and completion of the ICAP
   b. Face-to-Face administration is required
   c. The administering Support Coordinator will do an in-person interview with the applicant/person served

d. In cases where the applicant/person served has limited communication, the Support Coordinator can include a caregiver (i.e., someone who has close, daily involvement) who is most familiar with the abilities of the person
e. The ICAP is NOT to be given to a provider, staff person, OR family member to complete on their own.
f. The following sections of the ICAP must be completed:
    - Client information
    - Section A. Descriptive Information
    - Section B. Diagnostic Status
    - Section C. Functional Limitations and Needed Assistance
    - Section D. Adaptive Behavior (examples include: declining health, significant changes in behaviors, changes to living situation, etc.

**NOTE: Sections F, G, H, I, and J are not completed and/or are scored as none. The Person-Centered Plan communication guide and assessment should be used to further evaluate support and service needs)**

4. The completed ICAP must include the date, signature, and title of the Support Coordinator completing the assessment.
5. The applicable scores yielded by the ICAP administration are entered into the Eligibility Assessment in the web- based application.
6. For reference, the completed ICAP protocol is scanned and uploaded to the record of the applicant/person served in the web-based application.

## B.1.5 APPROVED TESTS AND ASSESSMENTS FOR WAIT LIST

### B.1.5.a Approved Tests and Assessments for Wait List Eligibility Determination

**Responsible Office:** Offices of Regional Community Services
**Reference:** Administrative Code 580-5-30-.14 Eligibility and Level of Care Determinations for Medicaid Waiver Programs
**Effective:** December 14, 2024

**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 individuals with Intellectual Disabilities (ID Waiver) and for the Alabama Living at Home Waiver (LAH Waiver).

**Purpose/Intent:** Assist individuals who are seeking placement on the Alabama Department of Mental Health Division of Developmental Disabilities Waiver Waiting List with information related to approved psychological testing used to establish eligibility for ID and LAH Waiver services.

**HCBS Waivers**: ID, LAH

**Key Terms:**
Division of Developmental Disabilities Information Management System (DDD IMS)
RFA (Request for Action (RFA)

Inventory for Client and Agency Planning (ICAP)
Community Services Director (CSD)
Individualized Educational Plan (IEP)
Comprehensive Support Services (CSS)
Behavioral & Psychological Evaluator (BPE)

**Procedures:**
The following assessments/tests will be accepted by the AL Department of Mental Health- Division of Developmental Disabilities to determine eligibility for enrollment onto the AL- Statewide Waiting List for HCBS Medicaid ID Waiver Services. These measures satisfy the professional standards for validity and reliability required for their use in the analysis of general intellectual functioning in persons being evaluated for ID. The same is true for standardized versions of these measures available for use with individuals whose primary language is not English. Of note, qualified professionals should avoid the administering of the same intelligence test less than two years apart:

1. **APPROVED TESTS FOR CHILDREN, ADOLESCENTS, AND ADULTS**
   a. Wechsler Intelligence Assessment Scales- Applicable Age Range Appropriate Versions Listed Below
      - WPPSI- Wechsler Preschool & Primary Scale of Intelligence-Ages: 2:6 – 7:7
      - WISC- Wechsler Intelligence Scale for Children- Ages: 6:0–16:11
      - WAIS- Weschler Adult Intelligence Scale- Ages: 16:0-90:11
   b. SBI- Stanford-Binet Intelligence Scales- Ages: 2:0- 85:0

2. **APPROVED ADDITIONAL TESTS FOR YOUNG CHILDREN-** The following tests will be accepted as they are more widely used specific to infants and very young children. They will be weighted applicable to age of applicant and availability of other supporting documentation that supports a diagnosis of Intellectual Disability, to include an estimated or equivalently assigned FSIQ score from the qualified professional in cases where the below tests are not designed to produce an FSIQ.
   a. BSID- Bayley Scales of Infant and Toddler Development- Ages: 1 month- 42 months
   b. BDI- Battelle Developmental Inventory - Ages: Birth- 7:11
   c. DAYC- Developmental Assessment of Young Children- Ages Birth-5: 11
   d. K-ABC- Kaufman Assessment Battery for Children- Ages: 2:5- 12:5/ K-ABC2 revised in 2004 for Ages 3:0 and 18:0

3. **APPROVED TESTS FOR INDIVIDUALS WITH A COMMUNICATION IMPAIRMENT-** The rationale for selecting a nonverbal measure should be clearly explained by the qualified professional in the assessment report.
   a. CTONI- Comprehensive Test of Nonverbal Intelligence- Ages: 6:0 through 89:11
   b. UNIT- Universal Nonverbal Intelligence Test– Ages: 5:0 to 21:11
   c. WNS- Wechsler Nonverbal Scale- Ages: 4:0-21:11

4. **The below additionally listed tests are accepted for review as part of eligibility determination.** They must be accompanied by additional significant sources of supporting documentation (See described below). In isolation, these assessments will not be accepted as sufficient for eligibility determination:
   a. RIAS- Reynolds Intellectual Assessment Scale- Ages: 3:0- 94:0

b. Leiter International Performance Scale-3rd Edition- Ages: 3:0- 75:0
c. OTHER TESTS NOT LISTED WILL BE ACCEPTED FOR REVIEW WITH THE SAME STIPULATIONS LISTED ABOVE.

5. **APPROVED SUPPORTING DOCUMENTATION/ CORROLARY EVIDENCE**
   a. Results of all relevant educational, medical, social, or other assessments and records;
   b. Reports concerning the cause of the suspected intellectual disability;
   c. Types of services the individual has received or is receiving, whether through the school system, vocational rehabilitation, or other service systems;
   d. Records from the Social Security Administration specific to disability benefits; and
   e. Previous and current psychological, medical, and psychiatric treatments and diagnoses.

6. **ESTABLISHING ORIGIN OF INTELLECTUAL DISABILITY DURING THE DEVELOPMENTAL PERIOD**
   Evidence supporting origination of ID during the individual's developmental period, meaning before the 22nd birthday includes review of the following (as available):
   a. reports concerning the cause of the suspected intellectual disability;
   b. results of all relevant educational, medical, social, or other assessments and records; types of services the individual has received or is receiving, whether through the school system, vocational rehabilitation, or other service systems;
   c. records from the Social Security Administration specific to disability benefits; and
   d. previous and current psychological, medical, and psychiatric treatments and diagnoses.

7. **ADMH-DDD-SPECIFIC CONSIDERATIONS FOR ELGIBILITY DETERMINATION**
   ADMH-DDD has established a fixed IQ cut-off score of 72 to determine eligibility for HCBS Intellectual Disability Waiver programs (Application for 1915(c) HCBS ID Waiver: AL.0001.R09.06 - Jul 01, 2024 (as of Jul 01, 2024). Application for 1915(c) HCBS Living at Home Waiver: AL.0391.R04.06 - Jul 01, 2024 (as of Jul 01, 2024)). In some cases, a submitted qualified professional's assessment may result in an individual not meeting eligibility criteria to be placed on the Statewide Waiting list for HCBS ID Waiver services even though the individual has a diagnosis of ID based on DSM-5 criteria, including an IQ score higher than service eligibility criteria. It is important to note that criteria for clinical diagnosis versus criteria for eligibility of Medicaid HCBS service programs are different based on the foundation of the waiver and the population it is intended to target.

   Nevertheless, eligibility determinations will adhere to the defined ADMHDDD criteria to conclude that an individual has a qualifying diagnosis of ID under the agency's rules.

8. **"AGE OF ONSET" CLARIFICATION**
   For some applicants who will apply for services later into adulthood, for which school records no longer exist, the individual did not complete their education, or special education services were not even in existence at the time. In order to meet the age of onset criteria for Intellectual Disability, it is acceptable for the qualified professional who completes the current testing/evaluation to affirm the other required components of the definition also to include a written attestation regarding age of onset. This attestation must indicate that, based on other supporting evidence (such as that obtained from past hospitalizations), the intellectual disability has existed since the developmental period.

9. **WHEN A STANDARDIZED INTELLECTUAL ASSESSMENT CANNOT BE SUCCESSFULLY ADMINISTERED.**

In some cases, an individual's intellectual functioning may be severely or profoundly impaired, or an individual's limitations may be so extensive, that a full-scale IQ (FSIQ) score cannot be obtained from a standardized intelligence test. In these situations, an estimate of the individual's IQ score, or IQ score equivalent should be stated with clinical justification by the qualified professional. Additional supporting documentation must be submitted that reflects consistency with estimated or equivalently assigned score.

10. **WHEN ASSESSING CHILDREN UNDER THE AGE OF 5.**

The DSM-5 recommends a diagnosis of "global developmental delay" (GDD) for children under the age of five years when the clinical severity level cannot be reliably assessed during early childhood. Children to whom this diagnosis would apply are those who are "…unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized testing." The DSM-5 specifies that this category requires reassessment after a period of time.

Based upon clinical judgment, a qualified professional has the discretion to "override" the diagnosis of GDD in favor of a formal diagnosis of ID for children under the age of five, if current measures of intellectual and adaptive functioning fall more than two standard deviations below the mean for the child's age and, given consideration of pertinent background variables, it is the conclusion of the qualified professional that current deficiencies may represent a life-long condition.

However, in recognition that IQ scores can be flexible and unreliable at such an early age, a child who is diagnosed before age five should be reassessed with a full comprehensive assessment at age five by a professional specifically trained to assess children, or earlier if the child demonstrates acquisition or loss of skills that affect general intellectual ability. It is important to note that, the reassessment may determine need for continued services or warrant a disqualification of waiver eligibility.

11. **USE OF BRIEF ASSESSMENT MEASURES**

Qualified professionals are discouraged from using/submitting brief tests of intelligence (i.e. Kaufman Brief Intelligence Test- KBIT, Slosson Intelligence Test, Wechsler Abbreviated Scale of Intelligence-WASI) to establish an individual's initial eligibility for HCBS waiver programs. However, in limited situations an exception may be warranted. For example:

a. The individual presents with a well-established, documented testing history based on broad-based batteries and brief test results are consistent with testing history;
b. The individual participated in multiple cognitive tests that yielded consistent scores, yet a more current IQ score is required and there is not present availability of a comprehensive measure that can be conducted.

The rationale for use of a Brief measure and justification for its use in the psychological report must be explained by the qualified professional. However, any significant change (including a decline or improvement) in functioning since the last evaluation would rule against the use of a brief test. In cases where there is not appropriate justification for the use of a brief IQ test, the evaluation may be disqualified as part of the eligibility review.

# CHAPTER 2
# INDIVIDUAL RIGHTS

## B.2.1 APPEALS PROCESS

**Responsible Office:** Offices of Community Programs, Offices Support Coordination, and Offices of Waiver Appeals
**Reference:** 42-CFR 431.210 (Subpart E); ID and LAH Waivers and Community Waiver Program (CWP); Rule No. 560-X-35-.17; Rule No. 560-X-43-.16; Rule No. 560-X-52.15
**Effective:** Historical Practice
**Revised:** December 11, 2023

**Purpose/Intent:** Appeals function both as a process of clarifying and interpreting the criteria and standards by which the original decision was rendered as well as a process for error correction, when applicable regarding decisions made specific to the HCBS Waiver Programs for individual with Intellectual Disabilities.

The procedures below clearly outline the steps in the appeals process which include: notification of adverse action, requesting an appeal for an Informal Conference or Fair Hearing, and decision making and resolution for individuals: (a) who are denied service(s), choice of provider(s), or whose services are(b) suspended, reduced, terminated or delayed.

**HCBS Waivers:** ID, LAH, CWP

**Key Terms:**
Adverse Action
Notice of Action (NOA)
Appeal
Informal Conference
Fair Hearing
Community Waiver Program (CWP)
Special Review Committee (SRC)
Alabama Medicaid Agency (AMA)
Community Services Director (CSD)
Office of Waiver Appeals (OWA)
Appeal Request Form (ARF)
Review Panel
AMA Waiver Program Manager
Appeal Packet

**Procedures:**
The appeals process begins with a NOA (Notification of Action to an applicant). This notice will specify the reason for the adverse action and provide instruction for requesting an appeal of the decision if desired.

1. When an adverse action is determined, the determining office will send a NOA along with the Appeal Request Form (ARF) to the applicant.

2. If the applicant feels the decision was made in error, they may appeal the decision by submitting the ARF or a written request (i.e. handwritten or typed statement, letter and/or email requesting an appeal)for an Informal Conference via email to alabama.dmh@mh.alabama.gov or by mail to:

Alabama Department of Mental Health
Office of Waiver Appeals
P.O. Box 301410
Montgomery, AL 36130-1410

NOTE: If the applicant chooses to submit a written request instead of the ARF form, the following information must be included:

- The full name of the applicant,
- Contact information of applicant (mailing address and/or email),
- The full name of requestor of the appeal (if applicable),
- Contact information of requester, if different from the applicant (mailing address and/or email),
- Adverse action taken (denial, termination, suspension or reduction in services), and
- Reason for requesting an appeal.

3. The request for appeal must be received by ADMH-DDD within 15 calendar days of the effective date printed on the NOA.

4. Upon receiving the NOA or written request of appeal, the Appeals Coordinator will:
   a. Send a letter of receipt to the requestor of the appeal, or
   b. If received after 15 calendar days, send a letter to the requestor of the appeal noting that the appeal for an Informal Conference to ADMH is unable to be reviewed due to being received beyond the defined time limit.

5. Following the timely receipt of a request of appeal for denials of waiver eligibility, a panel of ADMH-DDD clinical professionals will be selected to provide a thorough review of the documents submitted in the original application and those submitted as part of the appeal request. The requestor of appeal may be contacted for more information and further supporting documentation. A decision will be rendered to uphold or reverse the original denial after review is completed.

6. Following the timely receipt of a request of appeal for the denial, termination, reduction or suspension of waiver services, the Appeals Coordinator will:
   a. Assemble a review panel, and
   b. Provide each member of the review panel with an appeal packet.

7. The members of the review panel will individually review the appeal packet and submit to the Appeals Coordinator an Initial Review of Denial form.

8. Appeals Coordinator will compile panel member's responses on the Initial Review of Denial form and send the official form to all panel members prior to the informal conference.

9. The Informal Conference will consist of either a thorough review of documents and discussion by the panel members or a teleconference which includes the individual and requestor of the appeal if different from the individual. The applicant will be able to choose which option best suits their needs for the Informal Conference by notifying the Appeals Coordinator. The requestor of the appeal will notify the Appeals Coordinator with their decision on the type of Informal Conference via email or by mail.

**INFORMAL CONFERENCE:**
The applicant is entitled to a review which may involve a teleconference, or a thorough review of documents.

1. **Review** - A review will be scheduled with the 1) individual and as appropriate, the individual's representative (ex., family, guardian, authorized representative), if they are the requestor of the appeal. The individual for whom an Informal Conference was requested can attend, if possible (for the teleconference option) if he/she is capable. In the event that the individual nor their representative is not present for their initially scheduled Informal Conference teleconference, they may request that it be rescheduled for a later date/time. If the individual and/or their representative does not attend the rescheduled Informal Conference teleconference, an appeal decision will be determined based on the review of documents and discussion completed by the panel members 2) selected panel members, which will consist of a combination of staff from another Regional office, staff within the DD Division employed at the Central Office who did not have a role in the original denial, and an AMA Waiver Program Manager, 3) Staff responsible for denying the RFA (Regional CSD, Wait List Coordinator, or CWP Director or a designee), 4) Individual's Support coordinator.

   The teleconference option will provide the individual and their representative the opportunity to offer additional supporting information. The panel will also utilize the time to ask any specific questions to the staff, individual and/or their representative.

2. **Decision Making and Notification** -The ADMH-DDD Appeals Coordinator and selected panel members will meet after the teleconference (if this option is selected) or at a scheduled date and time to discuss and reach a decision to either reverse, uphold, or pend the decision. If the appeal is pending the review of additional information, the below steps should be followed:
   a. The individual/family/representative will be notified via email and/or mail of the panel members request for additional information, along with the individual's support coordinator.
      - The individual/family/representative will have no more than 15 calendar days to provide the additional informational that was requested to the Office of Waiver Appeals. If the requestor of the appeal is unable to provide the additional information, they must notify the Appeals Coordinator who will relay that information to the panel members.
      - Once the additional information has been received, the Appeal Coordinator will distribute the additional information to the appeals review panel members to review individually.
      - After the additional information has been distributed, the Appeals Coordinator will set a time and date for the appeals review panel to meet again within 7 calendar days to discuss and decide on whether to uphold or reverse the original decision.
   b. Once a decision has been reached, the panel will complete the Review of Denial Form

indicating reasons for their decision.

c. The panel will select a panel participant to submit in writing the final informal conference decision made by the panel and all supporting information to the Appeals Coordinator.
d. The Appeals Coordinator will submit a letter to the Associate Commissioner for review and approval that includes the following:
   - Description of initial request that warranted a denial
   - Action(s) taken to review the appeal
   - Final informal conference decision (denial upheld or reversed) and supporting reason (resource or other information to support decision)
   - Effective date of decision (if appropriate)
   - Process for the option to request an AMA Fair Hearing should the denial be upheld by the Associate commissioner and the individual and/or their representative remain in disagreement with the decision.
e. Upon obtaining the Associate Commissioner's review and decision, the Appeals Coordinator will notify the individual and if applicable, the individual's representative (person requesting the appeal) in writing within 15 calendar days.
f. If the Associate Commissioner upholds the decision of denial, the Appeals Coordinator will include in the notification to the individual the process for requesting a Fair Hearing with AMA.
g. The Appeals Coordinator will upload the letter into ADIDIS, adding as a note to the recipient's record, and tag the individual's Support Coordinator, Director of Community Programs, Regional CSD, the ID/LAH/CWP Waiver Director, the Regional Office Fiscal Manager and others as appropriate. The Appeals Coordinator will send a copy of the letter to AMA program manager via email.

FAIR HEARING:
If the individual/guardian disagrees with the ADMH Associate Commissioner's decision, he/she can submit a request for a Fair Hearing to the Alabama Medicaid Agency (Medicaid). A written hearing request must be received by Medicaid no later than 15 calendar days from the date of the ADMH Associate Commissioner's response letter to:

Alabama Medicaid Agency
LTC Healthcare Reform Division
P.O. Box 5624,
501 Dexter Avenue Montgomery, AL 36103-5624

## B.2.2 DISSATISFACTION OF SERVICES/GRIEVANCE PROCESS

**Responsible Office:** Offices of Community Programs, Offices of Support Coordination, and Offices of Waiver Appeals
**Reference:** 42 CFR 441.3029d0. Intellectual Disabilities and Living at Home HCBS Waivers
**Effective:** December 16, 2024
**Revised:** January 3, 2025

**Purpose/Intent:** The Dissatisfaction of Services/ Grievance Process is a disclosure required by Alabama Medicaid Agency and is handled through the Alabama Department of Mental Health's Office of Advocacy

Services to ensure a person enrolling or already receiving HCBS waiver services and their legally authorized representative are aware that they have a right to due process should they become unsatisfied with Medicaid funded services and/or service providers.

**HCBS Waivers:** ID, LAH, CWP

**Key Terms:**
HCBS
People
Support Coordinators
Regional Community Services Office Staff
Fair Hearing
ID - Intellectual Disabilities
LAH - Living at Home
Grievance

**Procedures:**

1. The Support Coordinator must review and complete the Dissatisfaction of Services/Grievance Process and Notification form with the participant at the time of new admission and annual redetermination. Prior to, and during the person-centered planning meeting, the participant is made aware that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing once they are selected from the wait list and services begin. A waiver participant should always be notified of their right to file a complaint/grievance when changing and/or adding waiver services. The waiver participant must sign and date the Notification form confirming the understanding of their rights. A copy of the signed Notification form must be filed securely and maintained in the waiver participant's file.

2. If a waiver participant becomes dissatisfied with a provider and/or the delivery of supports and services, he/she has the right to select a different provider and the Support Coordinator will assist with this process. This process may include an interdisciplinary team meeting to include a representative from the local Regional Community Services Office and/or an advocate to address any issues or concerns prior to a change in provider(s). However, if for any reason a participant believes that their rights have been violated in any way by ADMH/DDD support staff and/or a provider he/she can file a formal complaint/grievance in writing, or verbally directly to the Alabama Department Mental Health Office of Rights Protection & Advocacy. The Department maintains an independent Office of Rights Protection & Advocacy services, reporting directly to the Commissioner's office, which monitors programs, receives complaints through a toll-free advocacy access line during normal State of Alabama business hours (the number is required to be posted in every certified site and given to each waiver participant), and investigates any rights issue complaints received. A voicemail response is left on the phone line, encouraging after-hour callers to leave a message, which will be retrieved and responded to on the next regular business day. The recorded message also offers options for the caller to follow if more immediate assistance is required.

3. The types of rights issue complaints that may be reported and will be investigated fall into the following rights categories: a) Due process; b) Education; c) Complaints; d) Safe and humane environment; e) Protection from harm; f) Privacy/confidentiality; g) Personal possessions; h)

Communication and social contacts; i) Religion; j) Confidentiality of records; k) Labor; I) Disclosure of services available; m) Quality treatment; n) Individualized treatment or habilitation; o) Participation in treatment or habilitation; p) Least restrictive conditions; q) Research and experimentation; r) Informed consent.

4. Complaints of abuse, neglect, exploitation, or mistreatment are immediately referred to the responsible program and an investigation is also initiated by Advocacy staff or the program within 24 hours. Any other complaint that, in the opinion of the advocate, involves threat to health or safety is treated the same way. Other complaints are opened, responsible parties notified, and investigations are initiated as soon as possible but no later than seven (7) working days of the report, with the expectation that the investigation will be completed within thirty (30) working days.

5. The Office of Rights Protection & Advocacy will complete a thorough and adequate investigation of the complaint/grievance to provide a resolution. Resolution is required of the provider agency, which must submit a written report. If resolution requires ongoing monitoring, the responsible division's staff will provide this. If resolution requires court intervention, the federal protection and advocacy agency known as the Alabama Disabilities Advocacy Program, or the Alabama State Bar Referral Service may be contacted to arrange legal representation for the waiver participant. If the waiver participant is receiving services under the waiver and his/her complaint involves waiver related issues, and he/she cannot achieve satisfaction through the required resolution, the waiver participant and/or their representative will be referred to the Medicaid Waiver Program Manager for initiation of the Medicaid Fair Hearing Process. This rarely occurs, because the authority of the DMH Office of Advocacy Services should be able to resolve most problems.

6. After a resolution is determined, the waiver participant will receive a written notification of the resolution within seven (7) business days of the completed investigation process (note: the investigation process can take up to thirty (30) working days).

7. If a participant chooses to file a grievance/complaint, a written request of a review of their case can be mailed or emailed by the waiver participant, representative, relative, advocate, attorney or other involved spokesperson of their choice to the ADMH Office of Rights Protection & Advocacy. An individual can also contact the Office of Rights Protection & Advocacy toll free number as described in (2).

Alabama Department of Mental Health
Offices of Rights Protection & Advocacy RSA Union Building
100 North Union Street
P.O. Box 301410
Montgomery, AL 36130-1410
Phone: 1-800-367-0955
Fax: 334-242-0747
Email: Alabama.DMH@mh.alabama.gov

All grievance/complaints must be filed, stored properly, and made available to AMA on a quarterly basis. The quarterly reports to AMA must comprehensively list the waiver participant's information inclusive of the specific waiver of enrollment, the nature of the complaint/grievance, the finding(s) of the investigation, and the resolution. There should be a clear timeline provided for each case to ensure the process was reviewed and completed within the expected time frame. The quarterly reports must be sent to Alabama Medicaid Agency's Quality Assurance Director and ID, LAH and CWP Program Manager(s) via email no later than fifteen (15) days after the end of each quarter.

**Please click the link below to access form:**

**DISSATISFACTION OF SERVICES GRIEVANCE FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Dissatisfaction-of-Services-Grievance-Form-CWP.pdf

# CHAPTER 3
# SUPPORT COORDINATION

## B.3.1 MANDATORY CWP SUPPORT COORDINATION TRAINING

**Responsible Office:** Community Waiver Program
**Reference:** Administrative Code Chapter 580-5-30 (12); CWP MOU Between ADMH and AMA; ADMH Policy 50-10 Staff Training and Development
**Effective:** January 12, 2022
**Reviewed:** January 5, 2025

**Statement:** Support Coordination Services are provided directly by ADMH and/or through contract with eligible 310 agencies to serve enrollees in the Community Waiver Program.

**Purpose/Intent:** To ensure a qualified/competent Support Coordination Workforce in the delivery of services in the Community Waiver Program.

**HCBS Waivers:** CWP

**Key Terms:**
Alabama Department of Mental Health (ADMH)
Community Waiver Program (CWP)
Division of Developmental Disabilities (DDD)
Person Centered Plan (PCP)
Alabama Medicaid Agency (AMA)

**Procedures:**
1. Upon completion of New Employee Orientation, as required by ADMH, all persons employed as CWP Support Coordinators shall complete a specialized training curriculum prior to providing services under the CWP.
2. The Initial CWP Specialized Training Curriculum shall include training and information on the following topics: Introduction to Community Waiver Program; ADMH Overview; Advocacy and Rights; Rehabilitation Services; CWP Scopes of Services; CWP Self Directed Services; Medicaid State Plan; Person Centered Planning; Behavior Supports; HCBS Rights Modifications; Incident Prevention and Management; ICAP and ADIDIS. (Reference CWP Training Master List pages 6-8)
3. Annual refresher training shall be required for the following: Person Centered Planning; Incident Prevention and Management and ICAP.
4. Additional trainings shall be provided on all DDD Operational Guidelines specific to the CWP. (Reference DDD Operational Guidelines for CWP)
5. CWP Director, in conjunction with CWP SC Supervisors as appropriate, shall conduct an objective and measurable evaluation of each SC's skills and knowledge, to ensure SC is competent and qualified to perform duties. SC's knowledge, competency and qualifications shall be assessed specifically in the following areas: Understanding CWP Scopes of Services; Conducting and Completing Person Centered Interview Questionnaire; Completing Person Centered Plan; Completing an ICAP; the Incident Prevention and Management System (IPMS); and Completing Comprehensive Progress Notes in ADIDIS.
6. Training on the above areas shall be conducted annually; however, may be conducted more frequently dependent upon an SC's performance.

7. Results of SCs' performance on the above competency training areas shall be documented in the SC's mid and annual performance appraisals.

## B.3.2 GUIDELINES FOR APPROVING SERVICES AND SUPPORTS TO BE AUTHORIZED IN THE PCP

**Responsible Office:** Community Waiver Program
**Effective:** December 10, 2021
**Revised:** January 12, 2022
**Reviewed:** January 5, 2025

**Statement:** ADMH/DDD must assure CWP services and supports will be authorized and provided according to service definitions, caps and limitations as described in the approved CWP waiver documents. This includes ADMH/DDD assuring that CWP services will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including federal, state, local, and private entities.

**Purpose/Intent:** Describe how ADMH/DDD will approve CWP Person-Centered Plans in accordance with enrollment group expenditure caps, service definitions, service caps and limitations, while assuring that CWP services will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including federal, state, local, and private entities.

**HCBS Waivers:** CWP

**Key Terms:**
Division of Developmental Disabilities (DDD)
CWP Support Coordinator (SC)
Regional Fiscal Manager (RFM)
Person-Centered Plan (PCP)

**Procedures:**
When a CWP Support Coordinator (SC) completes the development or update to a Person-Centered Plan (PCP) for a CWP enrollee, the SC shall, as part of this work, list all CWP services authorized, including units, start/end date of authorization, total cost for each authorized service, and total cost for the PCP as a whole.

1. To obtain approval for the PCP, the SC shall immediately notify their Supervisor via secure email of the PCP being ready for review and approval. The email shall contain the following subject line: REQUEST FOR ACTION -CWP PCP READY FOR REVIEW/APPROVAL. The body of the email shall contain the CWP enrollee's name, date of birth and ADIDIS case number.
2. Upon receipt of an email notification regarding a PCP being ready for review and approval, the Supervisor shall review the PCP within three (3) business days. Approval must assure CWP services and supports are authorized according to the following:
    a. Services will be utilized in ways that are consistent with the approved service definitions
    b. The amount of each service listed in the PCP is within the cap established for the service, given the individual's CWP enrollment group and any other criteria dictating the cap for the service. If

one or more services are being requested in an amount above the cap, a Request for Action has been completed (see CWP OG B.3.3 Request for Regional Action (RFA).

c. Services authorized are consistent with any other limitations that apply to the service, given the individual's CWP enrollment group and any other criteria dictating limitations for the service. This includes assuring that:
   - No CWP service will be provided to an individual during the same unit of time as another CWP service is being provided unless explicitly permitted in the service definition.
   - A CWP service will not be authorized if a service that is the same in nature and scope is being provided to the CWP enrollee, regardless of the source of that service which may include federal, state, local, and private entities.

d. The total cost of the PCP does not exceed the expenditure cap for the individual given his/her CWP enrollment group. If the total cost of the PCP exceeds the expenditure cap, a Request for Action has to be completed (see CWP OG B.3.3 Request for Regional Action (RFA)) and approved before the PCP can be authorized.

3. The Supervisor shall approve the PCP if all of the above criteria are met and no additional RFA (as noted in 2B and 2D above) is required.
   - If a RFA is required as noted under 2B or 2D above, the Supervisor shall approve the PCP only after the RFA has been decided. The approved PCP shall reflect the RFA decision.
4. If the Supervisor can approve the PCP, the Supervisor shall notify the SC via a Note in ADIDIS and shall add the Regional Fiscal Manager as a recipient of the Note. Upon receipt of the Note, the Regional Fiscal Manager shall enter the authorizations for the PCP within two (2) business days.
5. If the Supervisor cannot approve the PCP because one or more of the above criteria is not met, the Supervisor shall notify the SC via secure email. The email shall contain the following subject line: CWP PCP DENIAL OF APPROVAL. The body of the email shall contain the CWP enrollee's name, date of birth and ADIDIS case number. It shall also contain a clear listing of the specific reasons why the PCP cannot be approved. Upon receipt of the email notification regarding denial of approval, the SC shall work with the CWP enrollee to revise the PCP to address what is necessary to obtain approval. Once the PCP has been revised accordingly, the SC will resend the PCP using the process described in 1 above.

**Note: Until further notice, if the service required reflects maximum service units, exceeds service cap, and/or exceeds enrollment group cap, the PCP and RFA must be submitted to the CWP Director for approval.**

## B.3.3 REQUEST FOR REGIONAL ACTION (RFA)

**Responsible Office:** Community Waiver Program
**Reference:** The ADMH-DDD provides oversight for the management of waiver services and under certain conditions, a request may require a Request for Regional Action (RFA) to be approved or denied.
**Effective:** November 17, 2021
**Revised:** March 24, 2023
**Reviewed:** January 5, 2025

**Statement:** The ADMH-DDD provides oversight for the management of waiver services and under certain conditions, a request may require a Request for Regional Action (RFA) to be approved or denied.

**Purpose/Intent:** To establish a process by which a Request for Action is reviewed, approved, or denied in the Community Waiver Program.

**HCBS Waivers:** CWP

**Key Terms:**
Request for Regional Action (RFA)
Person-Centered Plan (PCP)
Community Waiver Program (CWP)
Comprehensive Support Services (CSS)
Comprehensive Support Services Team (CSST)

**Procedures:**

1. When is an RFA required?
    - Request to exceed program limit on units for a service that is in the person's PCP
    - Request to exceed expenditure cap
    - Request to transition to a different enrollment group
    - Request for Breaks and Opportunities and/or Positive Behavior Supports for CWP
    - Enrollee, in process of first full person-centered assessment and planning process, who has an emergent need for either of these services
    - Skilled Nursing authorization
    - CSST Consultation
2. Any of the above situations require an RFA for approval. The Support Coordinator is responsible for preparing and submitting the RFA.
3. Before an RFA can be submitted by the Support Coordinator, there must be a discussion with, at minimum, the core PCP team [Support Coordinator, person, legal guardian if appointed, and provider(s) directly impacted by the change.] This discussion can be virtual or in-person, whichever best facilitates timely consideration of the need.
4. Once the core PCP team has agreed on the change that is needed, an RFA should be prepared by the Support Coordinator and submitted within three (3) business days of the PCP team meeting. Submission should be to:

| Select RFA Reason(s) | Reason for RFA | Support Coordinator Submits RFA To: | Recipient of RFA Action/Timeline: |
|---|---|---|---|
| | CSS **Psychiatric** Consultation ***(Attach CSS Consultation Form)*** | Regional Office Evaluator | Decision within 5 business day of receiving the processed RFA from the Regional Community Services Specialist IV (RO Evaluator). |
| | CSS **Crisis** Consultation ***(Attach CSS Consultation Form)*** | Regional Office Evaluator | Decision on RFA within 1 business day of receiving RFA and if approved, initiate CSST consultation within 2 business days of receiving RFA. |
| | Skilled Nursing Authorization | Regional Office Nurse | Decision within 26 business days of submitting RFA. |

| | | | |
|---|---|---|---|
| | Request for Emergency Breaks & Opportunities and/or Crisis Positive Behavior Supports at Enrollment | CWP Support Coordinator Director | Decision within 2 business days of submitting RFA. |
| | Request to Transition to Different CWP Enrollment Group | CWP Support Coordinator Director | Decision within 15 business days of submitting RFA. |
| | Other *(i.e. Individual Goods and Services/ Savings, etc)*: | CWP Support Coordinator Director | Decision within 15 business days of submitting RFA. |
| | Exceed Unit Cap for Specific Service | CWP Support Coordinator Director | Decision within 5 business days of submitting RFA. |
| | Exceed Expenditure Cap | CWP Support Coordinator Director | Decision within 15 business days of submitting RFA. |

RFA's sent to CWP Director: The CWP Director will formally document the decision in ADIDIS and communicate that decision to the Support Coordination Supervisor and the Support Coordinator within 1 business day of the action.

**Instructions for completing the RFA form:**

1. Type in the date the RFA is submitted to the appropriate recipient per the table above.
2. Type in the name of the specific recipient to whom the RFA is being submitted.
3. Type in your name and your Support Coordination Agency Name
4. Waiver Participant Information
   - Type in the name of the waiver participant
   - Type in the waiver participant's ADIDIS case number
   - Type in the address or P.O. Box of the waiver participant (include street number, street name, city, state, zip code, and apartment number (as applicable)
   - Type in the Provider Agency(s) for the individual that will be impacted by the RFA
   - Indicate Community Waiver Program Enrollment Group (select 1-5):
5. Action Requested:
   - Request to exceed program limit on units for a service that is in the person's PCP
   - Request to exceed expenditure cap
   - Request to transition to a different enrollment group
   - Request for Breaks and Opportunities and/or Positive Behavior Supports to meet
   - emergent need of CWP enrollee whose first full PCP is not yet in place.
   - Skilled Nursing authorization
   - CSST Consultation
6. Description of Request:

***NOTE*****:** *Waiver Services of a certain type or amount must be necessary and appropriate to support the participant's defined outcomes and assessed needed related to these outcomes or health & safety. Waiver Services are only provided if supports from other sources (E.g., natural supports; other programs or community services available to individual) are not available. Waiver services are designed to benefit the participant, to sustain natural/community-based living arrangements and sustain participation in competitive integrated employment and the broader community. CSST services are only available in active crisis or imminent crisis situations to complement but not duplicate any CWP services also being provided to the individual. Justification for the request is required. Documentation should be brief and concise and fully note the participant's need*.

7. Designated Decision-Maker Comments:

The designated decision-maker will review the RFA for final decision.

- Approved: Notify the Support Coordinator to initiate services who will then notify the participant and provider of services.
- Denied: Any adverse action requires the participant to be notified in writing with explanation of the adverse action included. The participant will be mailed their appeal rights with the notice of adverse action.
- Incomplete: There is not enough supporting documentation to decide about the requested service(s). RFA must be resubmitted.

The RFA will be signed by the designated decision-maker with the date the decision was determined.

**Please click the link below to access form:**

**REQUEST FOR REGIONAL ACTION & INSTRUCTIONS FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Request-for-Regional-Action-and-Instructions-CWP.pdf

## B.3.4 COMMUNITY WAIVER EMPLOYMENT SERVICES - AUTHORIZATION & ADRS INVOLVEMENT

**Responsible Office:** Community Waiver Program
**Reference:** Community Waiver Program 1915(c) & 1115 Documents
**Effective:** October 1, 2021
**Reviewed:** January 5, 2025

**Statement:** A person's ADRS case does not have to be closed for the CWP to provide employment service(s) that are needed, if the service(s) is not duplicative of the services that are available to the person through ADRS. The CWP may also provide employment services that are needed but not timely available to a CWP enrollee through ADRS.

**Purpose/Intent:** There are multiple scenarios in which employment services not available via ADRS, due to either ineligibility or timeliness of access, can be separately or concurrently authorized by the CWP for a CWP enrollee who has a need for these services.

**HCBS Waivers**: CWP

**Key Terms:**
Regional Community Services (RCS)
Intellectual Disabilities Waiver (ID)
Living at Home Waiver LAH)
Alabama Department of Rehabilitative Services (ADRS)
Community Waiver Program (CWP)
Information Management System (IMS)
Individualized Plan for Employment (IPE)

**Procedures:**

1. The CWP cannot cover specific employment services which are otherwise timely available to the person via ADRS. The person must seek out and attempt to obtain services through ADRS, and Support Coordinators must assist the person with this, as needed.
    a. If an employment service is authorized through CWP, the CWP Support Coordinator must first document in the person's DDD IMS record how they determined the service is not timely available to the person through ADRS.
2. For a particular CWP employment service to be considered "otherwise timely available to the person through ADRS", at the time this question is being considered by the CWP person-centered planning team, at least one of the following must be true:
    a. The person must have a current Individualized Plan for Employment (IPE) with the needed service(s) authorized in the IPE.
    b. The person (or the person's legal guardian, if applicable) with help as needed, must have recently (in last 30 days) contacted ADRS to seek ADRS services and as a result, ADRS must have facilitated the person signing an application for ADRS services.
        - If ADRS did not provide the person with an opportunity to sign an application for ADRS services, the Support Coordinator shall document this in the person's DDD IMS record, and the needed employment service(s) can be provided via the CWP.
        - If ADRS communicated to the person (or legal guardian, if applicable) or the CWP Support Coordinator, in writing or through other means, that the person is not eligible for ADRS services (either prior to or after signing an application), the Support Coordinator shall document this in the person's DDD IMS record, and the needed employment service(s) can be provided via the CWP.
    c. The person has successfully applied for, and been determined eligible for, ADRS services, and ADRS communicates to the person (or legal guardian, if applicable) or the CWP Support Coordinator, in writing or through other means, that the person will likely or definitely begin receiving needed ADRS services within 30 days.
        - If the person has successfully applied for, and been determined eligible for, ADRS services, but ADRS communicates to the person (or legal guardian, if applicable) or the CWP Support Coordinator, in writing or through other means, that the person will likely or definitely have to wait for more than 30 days to begin receiving needed services through ADRS, the Support Coordinator shall document this in the person's DDD IMS record, and the employment service(s) the person needs immediately (within 30 days) can be provided via the CWP.
        - For each 30-day period thereafter that needed employment service(s) remain unavailable to the person through ADRS (due to delays in determining eligibility, writing the IPE, locating providers and/or providers initiating service), the Support Coordinator shall document this in the person's DDD IMS record, and the employment service(s) the person needs immediately (within the next 30-day period) can be provided via the CWP.
3. The CWP may provide needed employment service(s) that are not timely available to the person through ADRS. This can include a situation where a person is receiving services from ADRS.
    a. If a person has a need for employment services that is in addition to what ADRS is providing, the needed service(s) can be paid for by the CWP, so long as the services do not duplicate what is being provided to the person through ADRS. This applies to any point in the milestones process where ADRS services are being provided.

b. In particular, during the 4th Milestone, it is expected that CWP employment services will be utilized if needed.

4. If a person is receiving ADRS service(s), but a needed employment service(s) is not authorized by ADRS (i.e., not included in the person's IPE), the Support Coordinator shall request that ADRS add it to the IPE. If ADRS does not do so within fourteen (14) calendar days, the Support Coordinator shall document this in the person's DDD IMS, and the needed employment service(s) can be authorized to be provided via the CWP, because the employment service(s) is needed and is not duplicative of what is timely available to the person through ADRS.

## B.3.5 INDIVIDUAL EXPERIENCE ASSESSMENT (IEA)

### B.3.5.a Initial - IEA

**Responsible Office:** Community Waiver Program
**Reference:** 2014 HCBS Rule
**Effective:** Historical Practice
**Revised:** July 1, 2024

**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 assessment 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 assessment will also help ensure Alabama is compliant with the HCBS Settings Rule.

**HCBS Waivers:** CWP

**Key Terms:**
People
Support Coordinators
CWP Planning & Quality Assurance Specialist

**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. See OG: B.5.5. New Settings HCBS Compliance.

2. For persons currently receiving Alabama Medicaid Waiver services, the initial IEA will be completed at the time of their first annual PCP assessment/meeting 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 via the information management system, tagging the monitors as a note recipient, within at least TEN {10) business days of the date the assessment was completed. [Original to the Regional Office Monitor, copies to the provider agency(s), Support Coordination Supervisor and Support Coordinator].

5. Follow up on any area NOT in Compliance shall be completed within TEN business days of date of assessment. 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 Supervisor.

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 assessments (original) should be forwarded to the Regional Office Monitors, and Support Coordination Supervisors. Thereafter, only surveys reflecting non- compliance should be forwarded to Regional Office Monitors and Support Coordinator. 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 C does not automatically indicate Not in Compliance.**

### B.3.5.b Ongoing Monitoring- IEA

**Responsible Office:** Community Waiver Program
**Reference:** CWP approved waiver applications; Code of Federal Regulation 42 CFR § 441.301(c)(4); Alabama Statewide Transition Plan; Alabama Administrative Code 580-5-30
**Effective:** July 25, 2022
**Reviewed:** January 5, 2025

**Statement:** Federal HCBS Settings Rule compliance requires Support Coordinators in CWP to ensure CWP participants have an experience that is consistent with the opportunities, rights protections, and freedoms to be ensured under the rule.

**Purpose/Intent:** To define procedure for ongoing monitoring of CWP participant experience to ensure compliance with federal HCBS Settings Rule.

**HCBS Waivers:** CWP

**Key Terms:**
Community Waiver Program (CWP)
Individual Experience Assessment (IEA)
Home and Community Based Service (HCBS)
Alabama Department of Mental Health Division of Developmental Disabilities (ADMH/DDD)
Support Coordinator (SC)
Planning & Quality Enhancement (P&Q)
Person-Centered Plan (PCP)
Intellectual Disability (ID)
Living at Home (LAH)

**Procedures:**
The following procedure applies for ongoing monitoring of CWP participants' experiences to ensure compliance with federal HCBS Settings Rule:

1. An IEA completed with each CWP participant is required annually. Therefore, the first time SCs must complete with CWP participants is when they reach one year of enrollment (when the PCP is updated at the one-year point). IEAs are then re-administered annually thereafter.

2. The ***only*** exception to #1 is if the CWP participant starts receiving any of the following services in a setting that the provider ***did not*** previously use for ID/LAH waivers:
   a. Community-Based Residential Services
   b. Adult Family Home Services
   c. Breaks & Opportunities (if being provided in a setting the provider owns/operates as opposed to the person's own home)
   d. Supported Employment-Small Group

**Note:** If the provider is delivering these services to the CWP participant in a setting they previously used for ID/LAH waivers, this exception does not apply.

If this exception does apply (because the setting being used was not previously used for ID/LAH waivers), the SC must administer the first IEA within 5 days (before or after) the 60th day the person is receiving services in the setting. After that, the IEA is administered annually as described in #1 above.

3. **VERY IMPORTANT**: The goal of completing the IEA with the CWP participant is to ensure the experience the participant is having is consistent with the HCBS Settings Rule requirements (OG: New Settings HCBS Compliance). Any issues identified by the Support Coordinator must be immediately shared with the Regional Office Monitor via note in the DDD Information Management System (ADIDIS) for HCBS Settings Compliance Review.

4. The RO monitor completes validation within 60 days of the provider completing the HCBS Compliance Checklist. The provider then has 30 days to make corrections that meet expectations for 100% compliance.

5. At 90 days, if provider does not meet 100% compliance with the HCBS Setting Rule, the TOA/replacement setting certificate is withdrawn, and Emergency facilitation of CHOICE meetings begin.

6. At 90 days, if provider meets 100% compliance with the HCBS Setting Rule , the TOA/replacement certificate remains in good standing.

7. The IEA form that must be used (attached to this OG) can be found in ADIDIS. Under the Assessment Tab, the SC must select Add Assessment and select "Individual Experience Assessment Survey (IEA)" from the drop-down box.

8. Completed IEA forms must be stored in ADIDIS by the SC in the Assessment Tab by selecting Save and Close Assessment.

**Please click the link below to access form:**

**INDIVIDUAL EXPERIENCE ASSESSMENT SURVEY FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Individual-Experience-Assessment-Survey-CWP.pdf

## B.3.6 REDETERMINATION

**Responsible Office:** Community Waiver Program
**Reference:** Administrative Code 580-5-30.14 Level of Care Determination for Medicaid Waiver Programs, 1915c Home and Community Based 1115 Demonstration
**Effective:** December 3, 2021
**Revised:** February 14, 2022
**Revised:** January 5, 2025
**Under Review:** April 28, 2025

**Statement:** Redetermination of Waiver eligibility (1915c and 1115) 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.

**HCBS Waivers:** CWP

**Key Terms:**
Division of Developmental Disabilities Information Management System (DDD IMS)
Inventory for Client and Agency Planning (ICAP)

Level of Care (LOC)
Interchange

**Procedures:**

1. The Support Coordinator:
   a. Completes supporting documentation uploaded to the DDD IMS Notes tab:
      - Signed Person-Centered Plan
      - Comprehensive Person-Centered Assessment Documentation and Planning
      - CWP - Freedom of Choice Form
      - Physical or RN Assessment (if necessary, only until physical is obtained).

        **NOTE: For the CWP, the attached annual physical form is recommended. If not used, Support Coordinators should encourage families to consider discussing all elements of this assessment with their physician.**
      - Updated ICAP
      - Psychological Evaluation (which documents presence of intellectual disability)
      - An Individual and Family History updated within 90 days of re-evaluation.
   b. These items should be reviewed and updated in ADIDIS through the Program tab:
      - Demographics
      - Diagnosis
      - Eligibility
      - Employment Status
      - Individual and Family History
   c. Completion of supporting documentation no later than the 15th day of the month prior to the expiration of the Waiver determination.
2. The Waiver Coordinator:
   a. Downloads the Redeterminations Due Report for the month at hand from DDD IMS, via the Reports tab (select Type: MR Clinical).
   b. Reviews supporting documentation uploaded to the DDD IMS Notes tab by the Support Coordinator
      - Signed Person-Centered Plan updated within the past year.
      - Comprehensive Person-Centered Assessment Documentation and Planning updated within the past year.
      - Physical or RN Assessment (if necessary, only until physical is obtained).
      - Updated ICAP
        - For CWP 1915c Enrollment Groups #1 to #4, ICAP score of 85 or lower is required for eligibility
        - For CWP 1115 Enrollment Group #5, ICAP showing at least one domain score of 480 or lower for eligibility
      - Psychological Evaluation (which documents presence of intellectual disability – IQ under 70)
      - An Individual and Family History updated within 90 days of re-evaluation.
   c. Prints the Level of Care (LOC) form from the Demographics tab.
      - For CWP 1915c Groups #1 -#4: Ensures eligibility is evidenced by at least 3 areas of life activity checked on the LOC.

- For CWP 1115 Group #5: Ensures eligibility is evidenced by at least 1 area, but not more than 2 areas, of life activity checked on the LOC.

d. Prints the person's Interchange screen and checks the Fund Eligibility to verify active status for Medicaid.

e. Reviews the Waiver documents in the Clients tab of DDD IMS [referenced tabs are in bold below]:
   - Opens the Diagnosis tab to ensure information there is consistent with the IQ level on the Level of Care (LOC).
   - Reviews the Eligibility Assessment under the Assessments tab (Psychological/ICAP/ABS).
   - Ensures it was completed within 60 days of the redetermination date.
   - Ensures the referenced IQ score is less than 70.
   - Ensures the referenced ICAP was completed within 2 years and updated at least annually.
   - Ensures the referenced ICAP score meets eligibility requirements:
     - For CWP 1915c Enrollment Groups #1 to #4, ICAP score of 85 or lower is required for eligibility
     - For CWP 1115 Enrollment Group #5, ICAP showing at least one domain score of 480 or lower for eligibility
   - Reviews the Comprehensive Person-Centered Assessment Documentation and Planning and Person-Centered Plan to verify the outcomes address the identified needs not otherwise addressed by non-CWP services and supports, and to ensure the Person-Centered Plan is signed by the CWP enrollee (and/or legal representative) and any CWP providers delivering services to the CWP enrollee.
   - Reviews the Person-Centered Plan to ensure the redetermination/initialed field is marked as "Yes" and to ensure Waiver services listed in the Person-Centered Plan match those represented in Authorizations.

3. 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.
4. If all is correct and eligibility remains evident, the Waiver Coordinator:
   a. Duplicates the previous year's RO Waiver Registration in the Assessments tab, updating for the current date and denoting as "Complete".
   b. Enters the Waiver record in the Programs tab and sets the RO Action to "Approved".
   c. Signs and dates the LOC.
   d. Scans and emails to the Mental Health Specialist II in DDD Central Office:
      - RO Waiver Registration
      - Interchange Screen
        (1) Scans and uploads LOC documents to the Notes tab in individual records in DDD IMS, tagging the responsible Support Coordinator.
5. The Mental Health Specialist II forwards the RO Waiver Registration and Interchange Screen to Medicaid for financial approval.
   a. Upon approval, individual waiver segments are added in the Programs tab in DDD IMS.
6. The Regional Administrative Assistant:
   a. Prints the LTC-2.
   b. Files the RO Waiver Registration, Interchange Screen, LOC, and LTC-2.
7. If the ICAP score has changed from previous administration, the waiver coordinator will notify

the Fiscal Manager.

**Please click the links below to access the forms:**

**FREEDOM OF CHOICE FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Freedom-of-Choice-Form-CWP.pdf

**ANNUAL PHYSICAL EXAMINATION FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Physical-Examination-Form-CWP.pdf

## B.3.7 REQUEST FOR PROPOSAL TO PROVIDE WAIVER SERVICES

**Responsible Office:** Community Waiver Program
**Reference:** ADMH/DDD Operational Procedures
**Effective:** October 1, 2021
**Revised:** March 31, 2022

**Statement:** When a person needs to select a service provider for a CWP service(s) in their Person-Centered Plan, a Request for Proposal to provide the service(s) is circulated to certified/available providers of the needed service(s) in the region where the person resides and/or requires the service(s).
**Purpose/ Intent:** The Request for Proposal is prepared by the CWP Support Coordinator with the goal of communicating essential information about the person served, such that certified/available providers may make an informed decision about their potential ability to successfully serve that person.

**HCBS Waivers:** CWP

**Key Terms:**
Community Waiver Program (CWP)
Person-Centered Plan (PCP)
Regional Community Services (RCS)
Memorandum of Agreement (MOA)
Request for Provider (RFP)
Behavior Support Plan (BSP)

**Procedures:**
1. The CWP RFP is prepared by the Support Coordinator within five (5) business days of a PCP meeting when one of the following occurs:
   a. A new person is enrolled in CWP, needed services have been identified and the individual is seeking a provider(s) for those needed services.
   b. A CWP enrollee has a need for an additional/different service and the individual is seeking a provider for that service
   c. A CWP enrollee has a service and wishes to change provider for that service.
2. The CWP RFP must include the following essential information*:

a. Type of service(s) needed
b. Outcome(s) in PCP the service(s) is to support
c. Amount of service(s) needed (units/frequency)
d. Schedule for service delivery if the person has specific scheduling requests
e. Unit rate for service(s) needed
f. Basic demographics of person (i.e., age, gender, city/county of residence, living situation, employment status)
g. Natural/family supports and community involvement
h. Strengths, interests, preferences, passions
i. How the person communicates – best strategies for communicating with the person and supporting the person's communication with others
j. How person is best supported (what works/what doesn't work)
k. How the person learns best
l. Physical abilities and challenges; mobility skills (note adaptive/medical equipment if applicable)
m. Mental health status including positive supports that work to avoid incidents/crises; note whether BSP exists for the person or is being developed
n. Medication(s) if applicable; type and amount of assistance from service provider anticipated to be needed to ensure timely/accurate medication administration (note self-administration or administration by natural support if applicable)
o. Self-care skills
p. Formal diagnoses other than ID (physical; psychiatric; medical)
q. Other CWP services the person is receiving or will soon begin receiving.

***The CWP RFP should always include the PCP that reflects the outcome(s) and service(s) being requested through the RFP. To the extent the required information listed above is included in the PCP, it does not have to be repeated in the RFP form itself.**

3. Within two (2) business days of completion of the CWP RFP, the Support Coordinator shares, with the person (and legal guardian/family if applicable), the list of all providers who offer the needed service(s), in the area where the person needs to receive them. The Support Coordinator verifies which provider(s) the person wants the RFP sent to.
4. The Support Coordinator immediately circulates the RFP, via email, to all providers selected by the person. Providers who receive the RFP are afforded seven (7) business days to respond to the Support Coordinator named on the circulated RFP. All providers that receive the RFP are expected to respond in some way within seven (7) business days.
5. If the RFP is circulated and receives no acceptances (willingness to serve) from providers, it will be circulated again with a response time frame of seven (7) business days.
6. If the RFP, after a second attempt, receives no responses from providers, the Support Coordinator will contact the Provider Network Manager for assistance to identify perspective providers.
7. In the event that no local provider can be identified, responds to the RFP, the person served may elect to have the RFP circulated in other fiscal Regions for consideration by providers in those areas. If this is the decision of the person, the Support Coordinator in the Region of the person's residence will share the RFP with the Waiting List Coordinator(s) in the Region of the person's residence who will

share with the Waiting List Coordinator in the Region(s) where the person chooses to seek services, and the RFP process noted above will then be followed there.

If the RFP receives no response from providers, either locally or statewide, the Support Coordinator Supervisor and Provider Network Manager will consult with the Community Services Director to identify prospective providers with compatible services offered.

**Please click the link below to access form:**
**CWP REQUEST FOR PROPOSAL (RFP) TO PROVIDER WAIVER SERVICES FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Request-for-Proposal-to-Provider-Waiver-Services.pdf

## B.3.8 COMPREHENSIVE SUPPORT SERVICES (CSS) TEAMS

**Responsible Office:** Office of Psychological and Behavioral Services
**Reference:** ADMH Administrative Code 580-5-30-.02 (2); ADMH Policy 540-1
**Effective:** Historical Practice
**Revised:** April 1, 2023
**Reviewed:** February 23, 2024

**Statement:** When individuals with intellectual disabilities served or on waitlist through one of the Alabama DMH Division of Developmental Disabilities (DDD) Home and Community Based Settings (HCBS) Waivers experience behavioral challenges and have need for interventions to prevent behavioral crises, the DDD established clinical professionals with advanced training in behavioral support services who are part of what is known as statewide Comprehensive Support Services (CSS) Teams to provide consultation.

**Purpose/Intent:**
The CSS teams were originally established to provide transition assistance and guidance for individuals with intellectual disabilities who were transitioning from institutional settings to home and community based settings as a way to aid in successful outcomes and mitigate crises situations that may have occurred.

Presently CSS provides assistance and training to HCBS waiver participants, and their family/natural supports, involved provider agencies, mental health centers, police and other community support organizations. This consultation service provides guidance to service providers and stakeholders who will implement behavior supports in their settings.

CSS services are intended to address significantly challenging, crisis related, and/or other behavior/mental health related situations that may lead to an individual experiencing psychiatric hospital admission, incarceration, or challenges to maintaining community living.

CSS Consultation services are designed to promote habilitation for the individual, resource skills for staff, and to increase the capacity and expertise of those involved in supporting the person, in the places where the person is being supported.
HCBS Waivers: ID, LAH, CWP

**Key Terms:**

CSS Teams
Positive Behavior Supports
Request for Action (RFA)

**Procedures:**

1. CSS teams assess the need for and assist with providing an array of supports to individuals who require specialized behavioral services, and if available, medical, psychiatric, and/or dental consultation when needed specifically due to behavior that is challenging.
2. CSS Teams provide training, information and resources to the greater service community at large to assist them in developing internal capacity related to supporting individuals with intellectual disabilities with behavioral needs who require their services.
3. Comprehensive Support Services teams are located in Birmingham, Decatur, Tuscaloosa, Montgomery, and Mobile, within the five ADMH-DDD Regional Community Services offices, offering state-wide coverage.

4. Consultation Services Provided:
   a. Training- for Staff, agencies, support persons, and other community members on behavior related topics, procedures, and/or ADMH Behavioral Services Procedural Guidelines
   b. Recommendations - regarding individual experiencing behavioral challenges or acute changes
   c. Technical Assistance- review related to Behavior Support Plans/Psychotropic Med Plans, guidance data and behavior tracking
   d. Clinic - Medical/Dental/Psychiatric Telehealth Consultative services.
5. Who should be referred:
   - Individuals with ID who are receiving HCBS Waiver program services and are exhibiting challenging behaviors with the potential to escalate into a crisis situation; or are experiencing behavioral challenges that are high risk, and/or harmful to self or others; or exhibiting behaviors that may lead to experiencing psychiatric hospital admission, incarceration, or challenges to maintaining community living.
   - Those for whom current behavioral or medical/dental treatment strategies are not effective for a person otherwise eligible for services provided by CSS Teams
   - Persons who have numerous psychotropic medications or high doses prescribed
   - Persons who have begun exhibiting new challenging behavior(s)
   - Persons who have had recent psychiatric/behavioral hospitalization(s) and need guidance for implementing new strategies once back in community environment,
   - Involvement with law enforcement due to challenging behaviors
6. Accessing Services: In order to access Comprehensive Support Services Team consultation, provider agencies, families, and/or other primary support persons families should contact their assigned Support Coordinator who will communicate requests to the applicable Regional Community Services Office. Procedures have been established for processing and prioritizing referrals using the Request for Regional Action (RFA) procedures and CSS Consultation form. For persons with questions related to CSS Team services not covered within this operational guideline, please contact the ADMH DDD Director of Psychological and Behavioral Services. The contact information is listed here: https://mh.alabama.gov/division-of-developmental-disabilities/psychological-and-behavioral-services/.

**Please click the link below to access form:**

**REQUEST FOR CSS CONSULTATION FOR CWP PARTICIPANT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Request-for-CSS-Consultation-for-CWP-Participant-Form.pdf

## B.3.9 INTAKE BILLING PROCESS FOR SUPPORT COORDINATION

**Responsible Office:** Support Coordination Services and Fiscal Management
**Reference:** Administrative Code Chapter 580-5-31 and 580-5-31-14: ADMH Medicaid Waiver Programs; Operational Guidelines A1.1, A.1.2a, A.1.2b, A.1.2c, A.1.2.d, A.1.3, A.1.4, A.1.5,
**Effective:** December 14, 2024

**Purpose/Intent:** To describe the process Support Coordinators use to determine if an intake application is considered a complete application or incomplete application and when the SCA can submit billing for intake process.

**HCBS Waivers:** ID/LAH/CWP

**Key Terms:**
Inventory for Client and Agency Planning (ICAP)
Division Developmental Disabilities Information Management System (DDD IMS)
Region Office (RO)
Support Coordination Agency (SCA)

**Procedures:**
1. Categories of the Intake Application

    a. Complete Application: Once all eligibility documentation has been received and Inventory for Client and Agency Planning (ICAP) administered, the Support Coordination Agency (SCA) completes Eligibility Assessment, Criticality Summary and Diagnosis in the Division Developmental Disabilities Information Management System (DDD IMS). The Wait List application is submitted to the Region Office (RO) through DDD IMS for determination of eligibility. Eligibility documentation is reviewed by the RO Waitlist Coordinator to determine approval or denial of waiver admission to the Wait List. The SCA will submit the completed Intake Invoices via email to the designated Division Developmental Disabilities (DDD) fiscal office staff.

2. Incomplete Application:

    a. If the SCA is unsuccessful in contacting the applicant and/or their representative within 60 calendar days of the referral, the SCA must notify the RO Wait List Coordinator. The SCA is required to document all attempts made in an effort to contact the person and/or their representative in the DDD IMS. A reasonable effort to make contact would be two (2) documented phone calls and a letter mailed to the individual. The SCA will submit the completed Intake Invoices via email to the designated DDD fiscal office staff.

b. After the eligibility documentation has been received and the ICAP has been administered, the SCA will complete the Eligibility Assessment, Criticality Summary and Diagnosis in DDD IMS. The Wait List application is then submitted to the RO through the DDD IMS for determination of eligibility. If eligibility documentation is not sufficient to properly make a determination, the RO Wait List Coordinator will notify the SCA regarding the needed documentation necessary to make a determination. If the necessary documentation is not received within 60 calendar days of the request being made by the RO Wait List Coordinator, the application will be deemed incomplete.

3. Voluntary Withdrawal by Family:
   a. At any time during the intake process if the applicant or their family/representative informs the SCA that they no longer want to continue with the intake process, the SCA must notify the RO Wait List Coordinator through DDD IMS of the applicant's and/or family's decision to withdraw from wait list application process. The WL Coordinator will document receipt of notification from the SCA in the DDD IMS. The applicant/family will receive a generated letter from DMH confirming the conclusion of the application process.

4. Intake Billing Process:
   - The SCA will submit billing for intake using the Intake Invoice (see attached) after A, B, or C has been completed to the DDD fiscal office staff. All attempts (successful and unsuccessful) to contact the individual must be documented in the DDD-IMS.
   - SCA will complete the Intake Invoice form for every individual documenting the date and time the contacts were attempted and made with the individual and/or family member. SCA's will include all work within the process of the current intake to justify the payment including current Fiscal Year, Vendor Number, Contract Number, SCA name, physical address that must match the address in STAARS.
   - The Invoice Date is the date the invoice is submitted to DDD fiscal staff.
   - DDD Waitlist Coordinator will review the Intake application and associated documents within 60-70 calendar days of the referral date and enter in the Intake spreadsheet whether the SCA has satisfied the above requirements notated in A, B, or C and if DDD Fiscal can pay the invoice.
   - The invoice is reviewed, and all necessary information is confirmed by DDD Fiscal.
   - Upon the Waitlist Coordinator approval noted on the Intake Spreadsheet, DDD Fiscal will certify the invoices by obtaining the DDD Director of Fiscal Operations signature. The invoices will then be submitted to the ADMH Bureau of Finance for payment within 10 business days.
   - Then DDD Fiscal will enter a "Yes" or "No" response in the Intake spreadsheet regarding the payment of the invoice.

**Invoice Denied Payment**

1. If the payment is denied, the DDD Fiscal office will notify the SCA via email of the denial.
2. If the SCA receives a denial response that an invoice cannot be paid, the SCA should contact Director of Community Services and carbon copy the Director of Support Coordination to obtain clarity about the denial.

# CHAPTER 4
# PROVIDER REQUIREMENTS

## B.4.1 PROVIDER PERSONNEL QUALIFICATIONS AND TRAINING REQUIREMENTS

**Responsible Office:** Community Waiver Program
**Effective:** July 28, 2022
**Reviewed:** January 5, 2025

**Statement:** This Operational Guideline establishes for Community Waver Program Direct Service Personnel qualifications and training requirements for agency DSPs and Self-Directed Services DSPs.

**Purpose/Intent:** The purpose is to establish training guidelines for the providers of CWP services.

HCBS Waivers: CWP

**Key Terms:**
Employment and Community First (ECF)
Direct Support Personnel (DSP)

**Procedures:**

1. Standard Minimum Agency Direct Service Personnel Qualifications and Training Requirements:
   These apply to all CWP services other than: Peer Specialist Services; Family Empowerment and Systems Navigation Counseling; Financial Literacy and Work Incentive Benefits Counseling; Positive Behavior Supports; Occupational Therapy; Physical Therapy; Skilled Nursing; Speech and Language Therapy; Housing Counseling; Community Transportation; Remote Supports -Technology Installer and Provider; Assistive Technology and Adaptive Aids. For the requirements that apply to these services, see the section of this document titled "Non-Standard Minimum Agency Direct Service Personnel Qualifications and Training Requirements for Specific Services that Must Not Also Meet Standard Minimum Qualifications and Training."

   Qualifications
   a. Minimum age of 18.
   b. Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   c. Must pass a pre-employment drug screen.
   d. TB skin test if required by Alabama Medicaid Agency (see AMA Policy #WAV37).

2. Post-Hire Training Requirements:
   All courses listed below must be completed within 90 days. The first section "Before Serving People" must be completed before assigning staff to provide direct supports. The following courses may be completed prior to the schedule indicated below as long as all training is completed within 90 days.
   **Must complete the following training on the schedule noted below:**
   A. **BEFORE SERVING PEOPLE:**
      (1) Welcome to Employment and Community First (ECF Module)
      (2) Orientation (ECF Module)
      (3) Introduction to CWP (ECF Module)
      (4) Supporting People with IDD (ECF Module)

(5) Keys to Independence: Everyone Can Succeed (ECF Module)
(6) Supporting Community Participation (ECF Module)
(7) Standard Precautions ( Module)
(8) Signs and Symptoms of Illness/Medication Side Effects (ECF Module)
(9) First Aid (Certification required)
(10) CPR (Certification required)
(11) Incident Prevention & Management System (IPMS): reportable event (critical incident) identification and reporting (Content provided or pre-approved by ADMH/DDD)
(12) Infection Control (Content provided or pre-approved by ADMH/DDD)

Training on the specific service(s) the DSP will be providing. This should include the service definition, expected outcomes, and reasons the service is authorized (Content provided or pre-approved by ADMH/DDD).

Training specific to the individual(s) being served, including training on their person-centered plan and service implementation plan(s).

B. **Upon completion of the courses in #A2a, the following should be completed within the next 30 days**:
(1) Disability Rights Movement (ECF Module)
(2) The Importance of Full Citizenship and Valued Social Roles (ECF Module)
(3) Supporting People to Form and Keep Relationships (ECF Module)
(4) The Importance of Employment (ECF Module)
(5) Emergency Preparedness (ECF Module)
(6) Working with Person Supported, Families/Conservators (ECF Module)
(7) Supporting Self-Determination (ECF Module)

C. **Upon completion of courses listed in #A2b, the following courses should be completed:**
(1) Positive Behavior Supports (ECF Module)
(2) What Really Keeps People with IDD Safe (ECF Module)
(3) Home and Community Based Services (ECF Module)

3. Additional Agency Direct Service Personnel Qualifications and Training Requirements Applying to Specific Services that Must Also Meet Standard Minimum Qualifications and Training Requirements Noted Above:

<u>Employment Supports-Individual Employment Supports:</u>

a) Provider Agency Qualifications:
- Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment services.

b) Direct Support Professional Qualifications

- For Exploration, Discovery, Job Development Plan, Job Development and Career Advancement, and Co-Worker Supports, DSPs must qualify as a Job Developer. To do this, DSPs shall also meet the following qualifications: completion of a minimum of one certificate-based Job Development and Placement curriculum. DMH/DDD maintains and publishes on its website a current approved listing of such curriculums.

For Job Coaching, DSPs must qualify as a Job Coach. To do this, DSPs shall also complete and pass the online Training Resource Network Job Coaching and Consulting course before providing service (https://trn-store.com/catalog/job-coaching-and-consulting).

Employment Supports-Small Group Supports:

a) Provider Agency Qualifications
Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment service.

b) Direct Support Professional Qualifications
DSPs must also qualify as a Job Coach. To do this, DSPs shall also complete and pass the online Training Resource Network Job Coaching and Consulting course before providing service (https://trn-store.com/catalog/job-coaching-and-consulting).

Employment Supports: Integrated Employment Path Services:

a) Provider Agency Qualifications
Employs a program manager who will supervise DSPs providing these services and who is qualified to provide Supported Employment services by holding a CESP, ACRE or Customized Employment certification, or other qualification pre-approved by DMH/DDD, and who has at least two (2) years' experience providing Supported Employment or similar employment service.
Direct Support Professional Qualifications

b) DSPs must also qualify as a Job Coach. To do this, DSPs shall also complete and pass the online Training Resource Network Job Coaching and Consulting course before providing service (https://trn-store.com/catalog/job-coaching-and-consulting).

Community Integration Connections and Skills Training

a) Must have at least one (1) year of experience working directly with individuals with intellectual disabilities or other developmental disabilities.

b) Prior to service delivery, must complete at least sixteen (12) hours of training using content that augments what is available through ECF platform and that focuses on: the service definition; philosophy and values underpinning expectation of community inclusion for individuals with intellectual disabilities; effective strategies for facilitating community involvement, participation and contribution; facilitating relationships between people with ID and other members of the broader community; task analysis, systematic instruction with emphasis on application to teaching skills for community participation, involvement and contribution; other teaching

strategies that are effective for assisting individuals with ID to develop skills for maintaining relationships with others who do not have disabilities; how to develop, implement, evaluate, and as needed revise, a written teaching plan focused on acquisition of community participation, involvement, contribution and relationship skills.

c) An associate degree from an accredited institution in a human services field is preferable but not required.

Independent Living Skills Training

a) Must have at least one (1) year of experience working directly with individuals with intellectual disabilities or other developmental disabilities.
b) Prior to service delivery, must complete at least eight (12) hours of training using content that augments what is available through ECF platform and that focuses on: task analysis, systematic instruction with emphasis on application to teaching independent living skills and other teaching strategies that are effective with individuals with intellectual disabilities, how to develop, implement, evaluate, and as needed revise, a written teaching plan focused on acquisition of independent living skills.
c) An associate degree from an accredited institution in a human services field is preferable but not required.

Support Coordination

**Must complete the following training:**

- Welcome to Employment & Community First (ECF Module)
- Orientation (ECF Module)
- Introduction to CWP (ECF Module) (Add)
- Supporting People with IDD (ECF Module)
- Keys to Independence: Everyone Can Succeed (ECF Module)
- Supporting Community Participation (ECF Module)
- Standard Precautions (ECF Module)
- Disability Rights Movement (ECF Module)
- The Importance of Full Citizenship and Valued Social Roles (ECF Module)
- Supporting People to Form and Keep Relationships (ECF Module)
- The Importance of Employment (ECF Module)
- Working with Person Supported, Families/Conservators (ECF Module)
- Supporting Self-Determination (ECF Module)
- Positive Behavior Supports (ECF Module)
- What Really Keeps People with IDD Safe (ECF Module)
- Home and Community Based Services (ECF Module)
- Person-Centered Planning
- Alabama Department of Mental Health ADIDIS Training
- THERAP Training
- Serious Incident Prevention Management System Training
- Medicaid Home and Community-Based (HCBS) Settings Rule HCBS Modification
- Community Waiver Program Overview Training
- Inventory for Client and Agency Planning (ICAP) Training

- Self-Directed Services
- Medicaid Enrollment/Reinstatement
- Support Coordinator Relias Training
- CWP Documentation Training

**Non-Standard Minimum Agency Direct Service Personnel Qualifications and Training Requirements for Specific Services that Must Not Also Meet Standard Minimum Qualifications and Training Requirements:**

1. Peer Specialist Services
   - Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   - Must have experience relevant to successfully supporting other people with disabilities, including specific experience relevant to each topical area covered by this service that the Peer Specialists wishes to be qualified to address. There are a total of 4 topical areas covered by the service:
     a. Directing the person-centered planning (PCP) process;
     b. Understanding and considering self-direction;
     c. Understanding and considering individualized integrated employment/self-employment;
     d. Understanding and considering independent and supported living community living options.
   - Prior to service delivery, must complete training addressing the following topics:
     a. Disability Rights Movement (ECF Module or with content preapproved by ADMH/DDD)
     b. Training on the specific service the DSP will be providing including the service definition, expected outcomes, reasons the service is authorized (Content provided or pre-approved by ADMH/DDD)
     c. Training specific to the individual(s) being served, including training on their person-centered plan and person's reason/goal for referral for Peer Specialist Services
   - Prior to service delivery, successfully complete at least eight (8) hours of training in best practices for offering Peer Specialist Services for each of the topical areas covered by this service that the Peer Specialist wishes to be qualified to address.
   - Complete no less than two (2) hours of annual refresher training for each of the topical areas covered by this service that the Peer Specialist wishes to be qualified to address.

2. Family Empowerment and Systems Navigation Counseling
   - Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   - Prior to service delivery, must complete training addressing the following topics:
     a. Training on the specific service the DSP will be providing including the service definition, expected outcomes, reasons the service is authorized (Content provided or pre-approved by ADMH/DDD)
     b. Training specific to the individual(s) being served, including training on their person-centered plan and specific reasons for referral for the service

- Prior to service delivery, successfully complete at least eight (8) hours of training in best practices for working with families, working with individuals with intellectual disabilities, family empowerment strategies and community mapping techniques.
- Complete no less than two (2) hours of annual refresher training.

3. Financial Literacy and Work Incentives Benefits Counseling
   - Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   - Minimum of Associates Degree in human service or related field.
   - For Work Incentives Benefits Counseling: Must be a certified Community Work Incentives Coordinator (CWIC) or Work Incentives Practitioner (WIP).
   - Prior to service delivery, must complete training addressing the following topics:
     a. Training on the specific service the DSP will be providing including the service definition, expected outcomes, reasons the service is authorized (Content provided or pre-approved by ADMH/DDD).
     b. Training specific to the individual(s) being served, including training on their person-centered plan and specific reasons for referral for the service.
     c. For Financial Literacy Counseling: Prior to service delivery, successful completion of a curriculum focused on financial literacy and empowerment from National Disability Institute and offered by qualified trainer from NDI and/or ADMH/DDD.
     d. Successfully complete no less than four (4) hours of annual continuing education (for Work Incentives Benefits Counselor) or refresher training (for Financial Literacy Counselor) provided by ADMH/DDD.

4. Positive Behavior Supports
   - Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   - Must have worked in the Intellectual/Developmental Disability (IDD) field for five (5) years or more, two of which must have been at a professional level in a position that addressed challenging behavior or who worked in a related field (e.g., mental health).
   - Holds an appropriate BA/BS level degree, master's degree, other advanced degree above the level of masters or equivalent experience in a field related to human services such as psychology, social work, behavioral, disabilities or rehabilitation psychology.
   - Has completed DDD training in positive behavior supports and/or behavioral psychology.

5. Physical Therapy
   - Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   - Physical Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec.34-24-212.

6. Occupational Therapy

- Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
- Occupational Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec. 34-39-5.

7. Speech and Language Therapy
   - Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   - Speech Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7.

8. Housing Counseling Services
   - Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   - Prior to service delivery, must complete training addressing the following topics:
     a. Training on the specific service the DSP will be providing including the service definition, expected outcomes, reasons the service is authorized (Content provided or pre-approved by ADMH/DDD)
     b. Training specific to the individual(s) being served, including training on their person-centered plan and specific reasons for referral for the service
   - Must have specialized housing counseling training (with content approved by ADMH/DDD), certification and/or relevant experience in counseling people with disabilities on housing issues and understanding how housing issues impact people with disabilities and can be effectively resolved for people with disabilities.

9. Skilled Nursing Services
   - Nurses are licensed under the Code of Alabama; 1975 Sec. 34-21.

10. Community Transportation
    - Stand-alone transportation companies or individual transportation providers (not including CWP providers of other services that are also providing Community Transportation) must comply with the Alabama Motor Carrier Act and must be certified or be issued a permit to operate, as applicable, by the Alabama Public Service Commission. In addition, they must adhere to any local certification/licensure requirements.

11. Remote Supports: Technology Installer and Provider
    - Recognized and experienced vendor or Remote Supports technology with experience in at least two (2) other states and current capability to provide Remote Supports services in geographic areas covered by this waiver in State of Alabama.
    - Before service delivery, training on Incident Prevention & Management System (IPMS): reportable event (critical incident) identification and reporting (Content provided or pre-approved by ADMH/DDD)

12. Minor Home Modifications:
    - Must meet all applicable state (Alabama Code 230-X-1) and local licensure requirements.
    - Must meet all construction, wiring, and/or plumbing building codes, as applicable.

13. Assistive Technology and Adaptive Aids
    - Must meet all applicable state (Alabama Board of Home Medical Equipment Services Providers) and local licensure requirements.

**Standard Self-Directed Services Direct Service Personnel Qualifications**

- Prior to hire, must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
- For persons hired by recipients electing to self-direct services to provide the following services, no additional training is required beyond that represented in the service definition:
    - Personal Assistance – Home (including family providers)
    - Personal Assistance – Community
    - Breaks & Opportunities (Respite)
    - Community Transportation
    - Community Integration Connections and Skills Training
    - Independent Living Skills Training
    - For self-directed service personnel providing employment services, no additional training is required post-hire beyond that represented in the service definition; but the following additional pre-hire qualifications are required:
- For Exploration, Discovery, Job Development Plan, Job Development and Career Advancement, Self-Directed Services personnel must qualify as a Job Developer. To do this, the Self-Directed Services worker shall provide, to the FMSA, documentation of successful completion of a minimum of one certificate-based Job Development and Placement curriculum. DMH/DDD maintains and publishes on its website a current approved listing of such curriculums. The FMSA will maintain the documentation of the qualification in the worker's file.
- For Job Coaching, the Self-Directed Services worker must qualify as a Job Coach. To do this, the Self-Directed Services worker shall provide, to the FMSA, documentation of successful completion of the online Training Resource Network Job Coaching and Consulting course before providing service (https://trn-store.com/catalog/job-coaching-and-consulting). The FMSA will maintain the documentation of the qualification in the worker's file.

**For self-directed service personnel providing Skilled Nursing services (RN or LPN)**

- No training is necessary post-hire, but the FMSA must verify that the worker is a licensed Nurse under the Code of Alabama; 1975 Sec. 34-21. The FMSA will maintain the documentation of this pre-hire qualification in the worker's file.

## B.4.2 EXISTING CWP PROVIDER SEEKING TO ADD OR DELETE CWP SERVICES OR GEOGRAPHIC AREAS WHERE SERVICES ARE PROVIDES IN THE PROVIDER'S CONTRACT

**Responsible Office:** DDD HCBS Waiver Service Providers, ADMH-DDD Central/Regional Offices
**Reference:** OG New Settings HCBS Compliance; ADMH Administration Code 580-3-23-.08 (1) ADMH Policy 550-001
**Effective:** June 17, 2022
**Revised:** January 22, 2025

**Statement:** Ensure that Settings that receive Waiver Funding must be and maintain HCBS Compliance while establishing a process for existing, enrolled CWP providers to add or delete CWP services or in the counties in which they will provide those services in the providers contract.

**Purpose/Intent:** The purpose is to establish a process for existing, enrolled CWP providers to add or delete CWP services, or the counties in which they will provide those services, in the providers' contract.

**HCBS Waivers:** CWP

**Key Terms:**
Community Waiver Program (CWP)
Home and Community Based Services (HCBS)

**Procedures:**
The following procedures shall apply when a an existing, enrolled CWP provider requests to add or delete CWP services and/or counties served:

1. The provider will complete an updated CWP Application with the additions or deletions of the services, or counties where the provider will provide those services, clearly noted. If the provider requests to add a service setting, the setting must be HCBS Compliant, see OG New Settings HCBS Settings Compliance.
2. **If the provider is seeking to add a service(s),** the updated CWP Application must include an attachment for each new service/ service setting the provider is seeking to add, which addresses the following:
   a. Information demonstrating knowledge and understanding of the service(s) the provider is seeking to add and/or any experience, training or qualifications that the provider agency's staff have relevant to the service(s).
   b. The county(s) the provider is proposing to serve.
   c. For the first six (6) months after approval, provide the maximum number of new referrals the provider can accommodate on a monthly basis in each county where the provider is proposing to add the service.
   d. For each service the provider proposes to provide, please identify the minimum salary the agency plans to pay, and minimum benefits the agency plans to offer, to part-time and full-time direct service workers providing this service, given the reimbursement rate and billing rules for the service. [Benefits refer to the following: health insurance (include worker premiums); dental insurance (include worker premiums); vision coverage (include worker premiums); retirement;

paid vacation; paid holidays; paid sick leave; short and/or long-term disability coverage; life insurance.]

e. Description of provider's processes for development/maintenance of appropriate/up-to-date staffing schedules for each person receiving this service and, if applicable, small groups of individuals receiving this service.
f. Description of service initiation, after referral acceptance, to ensure services are reflective of the person's unique goals/outcomes and support needs.

3. **If the provider is seeking to delete a service(s) in one or more counties where the provider is approved to provide the service(s),** the updated CWP Application must include an attachment for each service the provider is seeking to delete, which addresses the following:
   a. Explanation of the reason for deleting the service.
   b. The specific county(ies) in which the provider is seeking approval to stop providing the service.
   c. For each county, the specific date which the provider is proposing will be the end date for providing the service.
   d. Information, by county, on how many current CWP participants receive the service from the provider and how continuity of service provision will be ensured for each of these CWP participants when the provider stops providing the service.

4. The updated CWP Application will be reviewed by the Provider Network Manager.

5. **If the provider is seeking to add a service(s),** the Provider Network Manager will approve if:
   a. A complete and sufficient attachment for each service (as described in 2 above) is included with the updated CWP application; and
   b. The CWP's current and/or anticipated future need for provider capacity for the service(s), in the county(ies) the provider is proposing to serve, supports approval of the provider's application to add service(s) to their existing CWP contract. [Note: The Provider Network Manager will utilize referral acceptance data and related reports from Support Coordinators, service initiation data and related reports from Support Coordinators, and plans for increases in CWP enrollments to determine if approval is appropriate. The Provider Network Manager will document the basis for the approval in the provider's file.]

**Note: The provider may be approved to add a service in some but not all of the counties for which the provider is requesting approval to provide the service.**

6. **If the provider is seeking to add additional counties for service(s) they are already approved to provide, the Provider Network Manager will approve if:**
   a. The CWP's current and/or anticipated future need for provider capacity for the service(s), in the county(ies) the provider is proposing to add, supports approval of the provider's application to add these counties to their existing CWP contract. [Note: The Provider Network Manager will utilize referral acceptance data and related reports from Support Coordinators, service initiation data and related reports from Support Coordinators, and plans for increases in CWP enrollments to determine if approval is appropriate. The Provider Network Manager will document the basis for the approval in the provider's file.]

**Note: The provider may be approved to add some but not all of the counties for which the provider is requesting approval to provide the service.**

7. **If the provider is seeking to delete a service**, the Provider Network Manager will approve if:
   a. The provider has submitted an adequate plan to ensure all of the CWP participants, receiving the service from the provider, will have another qualified and enrolled provider in place to continue the service when the provider stops providing the service.
   b. The CWP's current and/or anticipated future need for provider capacity for the service, in each of the county(ies) where the provider is proposing to stop providing the service, can be addressed through other available providers in the CWP network (including use of Stand-By provider if needed). [Note: The Provider Network Manager will utilize referral acceptance data and related reports from Support Coordinators, service initiation data and related reports from Support Coordinators, and plans for increases in CWP enrollments to determine if approval is appropriate. The Provider Network Manager will document the basis for the approval in the provider's file.

**Note: The provider may be approved for different end dates in different counties based on when any capacity needs created by the approval can be addressed.**

8. The Provider Network Manager will communicate the approval (with or without conditions) or the denial decision in writing to the provider within ten (10) business days of receiving the updated Application.

9. If the Application is approved, the approval will be sent to the Office of Certification Administration as an attachment to the Request for Certification form.

10. The Provider Network Manager will make the necessary changes in the Support Coordination spreadsheet and other related documents.

## B.4.3 HCBS: PROVIDER OWNED AND CONTROLLED PROPERTIES

**Responsible Office:** Office Community Services, Community Waiver Program
**Reference:** Intellectual Disabilities (ID) Waiver Appendix F; ADMH Administrative Code: 580-5-30.08(2); Federal Centers for Medicare and Medicaid Services (CMS) has determined that Home and Community-Based Services (HCBS) settings must have all of the qualities specified in 42 CFR §441.301(c)(4); OG A. 6.3.b. Promotion and Protection of Individual Rights
**Effective:** February 9, 2023
**Reviewed:** January 5, 2025

**Statement:** CMS has determined that HCBS settings must have all of the qualities specified in 42 CFR §441.301(c)(4) (i-v), based on the needs of the individual as indicated in their Person-Centered Plan (PCP). For provider-owned or controlled residential settings that serve individuals who are enrolled in an ADMH-DDD HCBS Waiver program, additional conditions specified in 42 CFR §441.301(c)(4)(vi)(A) through (E) must be met. Specifically, the unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the

individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. The State must ensure that a lease, residency agreement or other forms of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. For individually controlled units, tenants are expected to sign a lease with landlords.

**Purpose/Intent:** This OG defines "Provider-owned or controlled setting" for the purposes of HCBS Waiver services administered through ADMH-DDD. This OG establishes standards to ensure that HCBS Waivers administered by the ADMH-DDD maximize opportunities for enrolled individuals to access the benefits of community living and receive services in the most integrated setting. The OG further outlines the requirement for ADMH-DDD's HCBS Waiver Service residential providers to ensure a legally enforced agreement – lease/rent or residency agreement - with the individual, and guardian if applicable, is in effect when the individual resides in a provider-owned or controlled setting. This OG also outlines the components of said agreement to include the HCBS regulatory requirements for provider owned and/or controlled settings where waiver participants receive residential waiver services.

**HCBS Waiver:** ID, LAH, CWP

**Key Terms:**
Residency Agreement
Residential Home
Tenant
Legal Representative
Fair Market Rent (FMR)
Appeals Process for Adverse Actions
Request for Action (RFA)
ADMH-DDD

**Procedures:**
1. Person-Centered Plans must reflect that the Individual was provided choice of non-disability settings.
2. Person-Centered Plans must support the Individual's/tenant's choice of provider and Residential Home among other providers and settings to include non-disability options.
3. Lease/Rent or Room & Board charges when provider owns or controls property:
   a. A specific monthly amount must be established for rent/room and board charges as determined by the following:

      - Documentation must reflect rent consistent with Fair Market Value (FMV) in the City/location of the property and rent must be fairly allocated among others considered residents in the Residential Home. To determine FMV use the following link https://www.rentdata.org/states/alabama/2022
      - Room and board refer to the cost for the provision of meals, a unit or room to sleep, laundry, basic utilities, and housekeeping. It does not mean direct support for daily living skills. Providers should regularly calculate room and board expenditures and ensure those costs are fairly allocated among the number of individuals in the setting.

- Any damages determined to be in excess of normal wear and tear attributed to individual/tenant will result in a Person-Centered Planning Support Team meeting to determine the most equitable resolution. If damages are the result of challenging/destructive behavior, the support team will develop a Behavior Support Plan which will be reviewed and approved by both a Behavior Support Plan (BSP) Review Committee and a Human Rights Committee (HRC), consistent with the State of Alabama Department of Mental Health rules, standards and regulations.

4. Provider Expectations:
   a. When a residential setting is owned or controlled by a provider agency, as defined above, the provider must ensure a written lease and/or residency agreement is in place for each individual/tenant served in the setting.
   b. The Division has developed lease/rental or residency agreement guidelines that are attached to this OG. Providers lease and or residency agreement must include all requirements as described in the attached guidelines.

5. Modification of the Requirements:
   a. As an individual receiving services in a HCBS setting, the individual is afforded the rights as authorized by 42 CFR 441.301(c)(2)(xiii) & 42 CFR 441.530(a)(1)(vi)(F). There may be times when, due to health and safety risks, a right may be limited. A limitation to any of these rights will always be based on a specific assessed need and will not be implemented without the individual's informed, written consent or the informed, written consent of the individual's legal guardian.
   b. If a modification of an individual's rights in the lease/residency agreement is deemed required, it must be justified through the PCP. Further, implementation strategies and the modification must be reviewed by the provider's HRC.
   c. Rights modifications should apply only to the individual with the need for the modification. In addition, no rights modification should be implemented solely because it is convenient for the provider, or legal guardian, if applicable. Implementing a modification without consent of the individual and legal guardian if applicable, is prohibited.

**Please click the link below to access form:**

**RENT RESIDENCY AGREEMENT GUIDELINES FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Rent-Residency-Guidelines.pdf

## B.4.4 SPECIALIZED SERVICE PROVIDER ENROLLMENT

**Responsible Office:** Offices of Certification
**Reference:** 580-5-30-.01 Purpose; 580-5-30-.08 Community Service Provision; 580-5-30-.15 Freedom of Choice; ADMH Medicaid Waiver Programs; Waiver Provider Manual
**Effective:** July 1, 2023
**Reviewed:** January 5, 2025

**Purpose/Intent:** To provide a step-by-step process to a prospective provider in becoming qualified to deliver specialized services and supports.

**HCBS Waiver:** ID, LAH, CWP

**Key Terms:**
Specialized Medical Supplies (SMS)
Environmental Accessibility Adaptations (EAA)
Personal Emergency Response System (PERS)
Community Waiver Program (CWP)
State of Alabama Accounting and Resource System (STAARS)
Alabama Division of Intellectual Disabilities Information System (ADIDIS)
Provider Network Manager (PNM)
Person-Centered Plan (PCP)
Positive Behavior Supports (PBS)
National Provider Identifier (NPI)

**Procedures:**
This application is for waiver service providers who are not certified by the Alabama Department of Mental Health, Division of Developmental Disabilities (ADMH/DDD) and/or for businesses which are vendors of waiver-covered items such as Assistive Technology, Specialized Medical Supplies (SMS), Home Modifications, Environmental Accessibility Adaptations (EAA), Speech and Language Therapy, Occupational Therapy, Physical Therapy Personal Energy Response System (PERS) Level 1-3, and Remote Support services desiring to conduct business with (ADMH/DDD).

i. The prospective specialized service provider completes the Waiver Service Provider/Vendor Application and submits it to the Provider Network Manager (PNM) at ADMH.
   a. Additional required documents to be included with application:
      i. Copy of AL Business License (if applicable)
      ii. Registration with the AL Secretary of State
      iii. Proof of Liability Insurance
      iv. Certifications (if applicable)
      Positive Behavior Supports (PBS) Level 1-3
      Level 1 Provider – Either a Ph.D. or MA Board Certified as a Behavior Analyst
      Level 2 Provider – Either a Ph.D. or MA in Behavior Analysis, Special Education or related field and 3 years' experience working with persons with Developmental Disabilities. Level 2 providers with a doctorate do not require supervision. Level 2 providers without a doctorate must be supervised by either a Level 1 or Level 2 doctorate provider.

      Level 3 Provider – Either a Qualified Developmental Disabilities Professional (QDDP) as required in 43 CFR 483.430 or be a Certified Assistant Behavior Analyst (BCaBA). Level 3 Providers must be supervised by either a Level 1 or Level 2 doctorate provider.
      v. Each prospective provider will need to register for a National Provider Identifier (NPI) Enumerator https://nppes.cms.hhs.gov/#/
      vi. Each prospective provider will need to enroll in the State of AL Accounting & Resource System (STAARS) https://vendors.alabama.gov/

2. Once the application is submitted, the PNM will submit to the Advisory Attorney for ADMH, the name and email address of the prospective provider.
    a. The Advisory Attorney will send to the prospective provider, a link to KnowMyHire for payment and processing of the background check.
    b. KnowMyHire will provide the results of the background check to the Advisory Attorney who will then notify the PNM of the results.
        i. If the KnowMyHire reports prospective provider meets requirements, application moves to the next step.
        ii. If the KnowMyHire reports prospective provider does not meet the requirements, the application package is denied, and notification is sent to applicant.

***Alabama Medicaid Agency Guidance on Waiver Background Checks***

Applicants **must not** have convictions or pending charges for:

- Any crime of violence
- Any felony convictions as well as any pending felony arrests

The following are criminal convictions that would deny a prospective provider from becoming a provider:

- Reckless endangerment in the past 5 years
- Stalking in the second degree in the past 5 years
- Criminal trespass in the first degree in the past 5 years
- Violating a protective order in the past 3 years
- Unlawful contact in the first degree in the past 3 years
- Criminal mischief in the first degree in the past 7 years
- Unlawful contact in the second degree in the past year

The Operating Agency will have final discretion on the application of the above guidance and may implement more restrictive policy in relationship to the performance of Statewide Background Checks for employment.

3. After the complete application package is received from the prospective provider (including all additional required documentation) the PNM will review the documents.

If the application package is incomplete, the PNM will contact the prospective provider via email and/or phone requesting the missing information. Please note when your application is delayed, it stops the process of you becoming a Provider. The timeframe for completing the paperwork is 60 days.

4. Once the application is reviewed and approved, the PNM will send the following to the Provider Enrollment Specialist at Medicaid (Gainwell Technologies) heather.formby@gainwelltechnologies.com for Medicaid enrollment:
    a. Enrollment File (ID, LAH, and/or CWP form)
    b. Provider Agreement
    c. Provider Disclosure Form

5. AMA emails the enrollment form back to PNM with the Provider's Medicaid number.

6. The PNM forwards the completed Provider Enrollment Checklist form to ADIDIS Support at ddsupport.dmh@mh.alabama.gov . ADIDIS Support will then complete ADIDIS setup of the Provider.

7. The PNM sends the contact information of the new Provider to the Financial Manager at the Regional Office closest to the Provider's physical location and they will make contact to schedule training in ADIDIS for the new Provider.

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

# CHAPTER 5
# QUALITY MANAGEMENT

## B.5.1 PROVIDER RECRUITMENT, INITIAL CREDENTIALING AND RE-CREDENTIALING PROCESSES

**Responsible Office:** Community Waiver Program
**Reference:** 42 CFR § 441.301(c)4-5.
**Effective:** July 28, 2022
**Reviewed:** January 5, 2025

**Statement:** The CWP is designed to foster and sustain community living, community integration/participation and participation in integrated employment in the community. The CWP is designed to promote and create innovative supports for individuals receiving CWP services. Providers are recruited and initially credentialed based on an RFP process, meeting minimum qualifications as outlined in the approved CWP waiver applications, HCBS Settings Rule standards and obtaining at least a minimum score on preferred provider qualifications (PPQs). Once contracted, providers are supported through ongoing re-credentialing to maintain minimum qualifications and full HCBS Settings Rule compliance, and to further focus on continuous quality improvement, including achievement of quality above and in addition to compliance, and increasing their PPQ score over time.

**Purpose/Intent:** To implement a recruitment and credentialing process in which the highest performing service providers seeking to become CWP providers are selected and enrolled. To implement an ongoing provider credentialing process where CWP providers consistently maintain minimum compliance while also looking to improve their expertise and quality of service delivery to achieve performance beyond basic compliance. To effectively utilize data tracking to assist providers with these goals, resulting in demonstrated quality service provision individualized to each CWP participant served.

**HCBS Waivers:** CWP

**Key Terms:**
Community Waiver Program (CWP)
Preferred Provider Qualifications (PPQ)
Planning & Quality Assurance Specialist (P&Q)
Alabama Department of Mental Health/Division of Developmental Disability (ADMH/DDD)
Home and Community-Based Services (HCBS)
Request for Proposal (RFP)
Intellectual Disability (ID)
Living at Home (LAH)
Continuous Quality Improvement (CQI)
Temporary Operating Agreement (TOA)

**Procedures:**
1. CWP Provider Recruitment Process
   a. Providers are typically selected through an RFP process when additional provider capacity is needed. Potential Providers must respond to the RFP requesting services.

      Eligibility to respond to the RFP includes:
      Certified Community Providers in good standing with the Division of Developmental Disabilities. "In good standing" means a provider that has not been placed on Provisional status in the past

24 months and that has no substantiated findings of abuse, neglect, mistreatment, or exploitation within the past 12 months.

Other Experienced Providers of community services not yet certified or credentialed by the Division of Developmental Disabilities, who can submit sufficient information supporting their experience, ability, and capacity to provide the services sought through the RFP and who indicate in their response a commitment to achieve CWP Credentialing through ADMH's Division of Developmental Disabilities.

"Other Experienced Providers" does not include providers who have been previously decertified by ADMH or who have relinquished their Certification during a decertification process.

b. The RFP will be released via USPS, ADMH Website, STAARS Website, and newspaper ads.

c. After the RFP release potential providers may submit RFP questions or requests for clarification per the deadline stated in the RFP. After the deadline to submit RFP Questions the RFP Q&A will be posted on the ADMH Website.

d. As part of RFP scoring process, only those providers responding to the RFP that are determined to meet the Preferred Provider Qualifications (PPQs) by scoring a minimum of 12 on these qualifications (with points earned in at least three of the five areas) can be considered for selection. Note: achieving this PPQ score is just one element in determining overall score on RFP response.

e. As part of the RFP process, providers are selected based on intent to meet the specific need(s) for additional provider network capacity and the amount of additional capacity that is needed, as determined by ADMH. Providers meeting PPQs and scoring the highest are approved first.

- Of those providers not selected, the provider meeting the PPQs, and scoring the highest will be placed on a stand-by list. Stand-by providers will have first priority for selection when additional provider capacity is needed. ADMH will maintain at least one stand-by provider for each CWP service in each region.

f. Providers selected through the RFP process are formally notified by ADMH. Notification of selection status will be sent by USPS.

g. Some providers may be added to the CWP provider network after the first two years of the program operation, outside of the above RFP process, as part of accompanying an ID or LAH waiver participant choosing to voluntarily transition to the CWP unless there is an administrative exception for health and safety as reviewed by the Special Review Team.

2. CWP Process for New Providers

a. Providers selected for enrollment with the CWP will attend a Provider Orientation training session for CWP Credentialing.
b. Providers selected, if new, will pay $1,500 application fee for CWP Credentialing and must also submit an application for CWP Credentialing. The application fee is waived for the period of the CWP demonstration. Note: A provider only needs to pay the application fee the first time it is credentialed for the CWP. The provider can be recredentialed when required at no additional cost and may add services or counties of service to their CWP contract at any time, at no additional cost, subject to meeting Credentialing requirements for those services.
c. Review of the provider application and RFP response is conducted by the RFP Selection Committee. The Provider Network Manager confirms, through this review, that provider meets all necessary requirements and documents this confirmation prior to submitting to the Office of Certification (OCA).
    - All new CWP providers must meet the minimum qualifications as outlined in the approved CWP waiver applications, HCBS Settings Rule standards and verifying the minimum score required on PPQs.
        - For providers responding to any RFP, the response must contain evidence to confirm the provider meets all of these requirements.
        - For providers accompanying an ID or LAH waiver participant choosing to voluntarily transition to the CWP, ADMH will require the submission of the same evidence that is required in an RFP response.

    d. For providers using provider-owned or controlled residential settings for Community-Based Residential Services and/or out-of-home Breaks and Opportunities services, two things must occur:
        - The provider must submit a completed HCBS Settings Compliance Checklists via the Information Management System to the assigned Community Service Monitor within 15 days of receiving the TOA or replacement certificate with the exception of the IEA. Compliance. (See OG: New Setting HCBS Compliance)
        - Once the HCBS monitoring response is received and deemed complete by the Community Services Monitor, they will notify the CSD/designee that the setting is available for review
        - The Office of Life Safety and Technical Services must visit the physical setting(s) to be utilized, if the setting(s) has not already passed inspection by this Office. The setting(s) must pass this inspection in order to be used for CWP service delivery and in order for the Office of Certification Administration to issue a 6-month Temporary Operating Authority (TOA). If specific setting(s) to be used are not known or identified at the time a TOA is sought, the TOA can be issued. However, any provider owned or controlled residential setting subsequently identified to be used to serve a CWP participant must meet all HCBS Settings Rule standards and pass inspection by the Office of Life Safety and Technical Services before CWP services can be delivered in that setting.

    e. After 2a through 2c (and 2d if applicable) is completed, the Provider Network Manager sends the completed Request for Credentialing form to the Office of Certification Administration. The request will verify an application has been received and all requirements for TOA have been met through evidence submitted in response to the RFP and contained in the application. The Request may include additional service(s) and county(ies) that were not included in the proposal submitted for the RFP process, if the provider wishes to add these services and/or

counties and ADMH confirms both the need for additional provider capacity exists, and the provider meets the requirements for Credentialing of the additional service(s).

- In order for the Office of Certification Administration to issue the TOA for a new provider, ADMH will conduct a background check on the chief executive. The clear background check on the chief executive must be received in order for the provider to be issued a TOA by the Office of Certification Administration.
- While the background check is being done, the Provider Network Manager will send the provider the Provider Agreement and Disclosures for DD Systems Management. The provider must complete and return these forms in order to be enrolled in the DDD IMS and receive a Medicaid number for billing.

f. The Office of Certification Administration will issue a 6-month Temporary Operating Authority (TOA).
g. DDD IT staff will notify Medicaid of need to verify no past fraud and issue a provider number.
h. Medicaid will verify no past fraud and issue a provider number.
i. ADMH Information Systems enrolls the provider in the DDD IMS.
j. If necessary, providers may back bill to start date(s) of any authorized services.
k. Based on the service(s) the provider is approved for, the provider will be expected to identify appropriate program manager(s) to participate in additional training about the service(s) requirements and expectations.
l. If the TOA expires before the provider begins serving CWP enrollees, or before the full initial Credentialing process is completed, the Provider Network Manager can request from the Office of Credentialing Administration an extension of the TOA for an additional six months. Requests for additional extensions can be made if needed.

**Please click the links below to access the forms:**

**CWP PROVIDER APPLICATION FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Provider-Application-Form.pdf

**CWP SERVICE PROPOSAL FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Service-Proposal.pdf

**PREFERRED PROVIDER QUALIFICATIONS (PPQ) INFORMATION REQUEST FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Preferred-Provider-Qualifications-Information-Request.pdf

## B.5.2 EMERGENCY NEED FOR BREAKS AND OPPORTUNITIES (RESPITE) AND/OR CRISIS POSITIVE BEHAVIOR SUPPORTS

**Responsible Office:** Community Waiver Program
**Reference:** CWP RFA
**Effective:** November 5, 2021
**Revised:** March 31, 2022
**Reviewed:** January 5, 2025

**Statement:** In the event a person enrolled in the Community Waiver Program (CWP), who is awaiting completion of the first full person-centered assessment and planning process, has an emergent need for Breaks & Opportunities (Respite) or Positive Behavior Supports services, DDD may temporarily authorize Breaks and Opportunities and/or Positive Behavior Supports until the first full person-centered assessment and planning process is completed and a full Person-Centered Plan (PCP) is put in place.

**Purpose/Intent:** In order to preserve the safety and security of the person and others, Breaks & Opportunities and/or Positive Behavior Supports may be provided to a person without a full person-centered plan (PCP) in place that authorizes these services, if there is substantiated documentation that the person has an emergent need for one or both of these services to avoid institutional, in-patient or other out-of-home placement (e.g., residential services).

**HCBS Waivers:** CWP

**Key Terms:**
Division of Developmental Disabilities (DDD)
Regional Community Services (RCS)
Support Coordination Supervisor (SCS)
Person-Centered Plan (PCP)
Request for Action (RFA)

**Procedures:**
1. Should a person enrolled in the Community Waiver Program (CWP), who is awaiting completion of the first full person-centered assessment and planning process, have an emergent need for Breaks & Opportunities or Positive Behavior Supports services, the assigned Support Coordinator may request those services, within established service limits based on the CWP enrollment group of the person.

2. The assigned Support Coordinator submits this request to Support Coordination Supervisor electronically via the web-based application using the CWP Request for Action (RFA) form.
a. The Support Coordinator will include with this RFA:
• Documentation of the rationale for providing the requested services prior to admission to Waiver services; and
• Documentation to substantiate the need and the rationale for providing the requested services prior to admission to Waiver services.
b. The Support Coordinator will tag the corresponding Support Coordination Supervisor (SCS) and the Director of the CWP in this notification.

3. Within three (3) business days, the SCS will perform a comprehensive review of the documentation provided in support of the request for providing the requested services prior to admission to Waiver services, including all available history and assessments.
a. A temporary approval (up to 90 days) to provide the requested service(s) may be granted if it is determined that, without the requested service(s), the person is at risk of being institutionalized, entering in-patient care, or requiring other out-of-home placement (e.g., residential services) prior to having opportunity to begin receiving CWP services through the first full PCP.
b. The SCS will forward the RFA, supporting documentation and the decision to the CWP Director and give one (1) business day for the CWP Director to approve.

c. If the CWP Director is not available to determine authorization, the request should go to the Associate Commissioner for decision-making and who will notify the SCS of approval or denial.
d. The SCS will electronically then notify the assigned Support Coordinator of the decision on the RFA via the web-based application, by the standard RFA process.

4. If applicable, upon notification of approval to provide Breaks and Opportunities and/or Positive Behavior Supports to the person, the assigned Support Coordinator will add the service(s) to the person's initial PCP that was used to authorize Support Coordination. The initial PCP must reflect the service(s), including the appropriate amount, frequency, and duration.

5. The Support Coordinator will also identify available provider(s) of the needed service(s) and include the provider(s) in the initial PCP. Choice of provider is desirable but not required for this short-term, emergent need authorization.

6. The Support Coordinator will ensure any approvals of the changes to the initial PCP are approved as required in policy.

7. The Regional Fiscal managers are notified via the web-based application to authorize the services.

## B.5.3 PROVIDER NETWORK ADEQUACY, RECRUITMENT PROCESS *(Removed)*

## B.5.4 CWP INITIAL CREDENTIALING AND RE-CREDENTIALING PROCESSES

**Responsible Office:** Offices of Quality & Planning
**Reference:** 42 CFR § 441.301(c)4-5, ADMH Administrative Code 580-3-23-.08 (1) & (7); ADMH Policy 550-001, Operational Guideline New Settings HCBS Compliance
**Effective:** Historical Practice
**Revised:** July 1, 2024

**Purpose/Intent:** To implement an ongoing provider credentialing process where CWP providers consistently maintain minimum compliance while also looking to improve their expertise and quality of service delivery to achieve performance beyond basic compliance. To effectively utilize data tracking to assist providers with these goals, resulting in demonstrated quality service provision individualized to each CWP participant served.

**HCBS Waivers:** CWP

**Key Terms:**
Community Waiver Program (CWP)
Planning & Quality Assurance Specialist (P&Q)
Alabama Department of Mental Health/Division of Developmental Disability (ADMH/DDD)
Intellectual Disability (ID)
Living at Home (LAH)
Continuous Quality Improvement (CQI)

**Procedures:**

1. **CWP Credentialing and Continuous Quality Improvement Process**
    a. The CQI and Credentialing Process begins within 6 months of a provider agency actively providing services to a Person. During the TOA period, the Provider Network Manager will address any barriers within the Provider Recruitment Process for the provider to begin service provision.
    b. Ongoing credentialing, necessary for the provider to continue in the CWP network, occurs through monthly visits, conducted both virtually and in-person, by ADMH/DDD CWP P&Q Specialist. (See Attachment A: Credentialing Schedule of Annual Cycle Activities)
    c. The goal of the monthly visits is to meet with CWP providers, people receiving CWP services, their families/guardians/supports, and provider staff to assess performance of both compliance and quality indicators specific to each CWP service they are providing.
    d. Initial HCBS Compliance will be addressed through Regional Office Monitor via the HCBS Compliance Checklist as referenced in New Settings HCBS Compliance OG.
    e. Ongoing HCBS Compliance will be addressed as referenced in Provider Operational Guideline Manual Chapter 5, Section 5; included in references above. Additional oversight will be addressed through the Values Visit Workbook indicators - 2.11-2.15, 4.2, 4.7-4.8, 9.2 b)-9.2 d), and the Administrative Functions Visit Workbook indicators - 4.10-4.11.
    f. The visits also focus on determining CWP participants' satisfaction with services received and working collaboratively with the provider to identify opportunities for further quality improvement, including any technical assistance that could be provided by the CWP P&Q Specialist.
    g. Each monthly credentialing visit will focus on specific compliance and quality requirements for credentialing and include a review of the provider's alignment with those requirements. P&Q staff and providers will consider each requirement, and evidence of policy/practice consistent with each requirement, utilizing a digital tool via a private Microsoft Teams channel, specific for each provider agency.
    h. Rather than a once per year visit, this credentialing process is designed to be an ongoing, monthly process, during which the provider will be considered a credentialed CWP provider as long as they continue to be in alignment, and/or be actively engaged in the process of coming into alignment with the CWP provider requirements based off the Scopes of Services and moving toward ever-increasing excellence.
    i. For any areas found not to be in alignment with compliance and/or quality indicators during the credentialing process, the P&Q Specialist will support the provider to design a plan to bring areas identified into alignment. Each "Plan of Alignment" will document what the provider will do and how ADMH/DDD will support those activities, as well as determine when they will be satisfactorily completed.
    j. For alignment needed to meet compliance indicators, the satisfactory completion of the Plan of Alignment must occur by the deadline agreed upon during the documentation review visit, to ensure the provider can maintain their "Good Standing" status.
    k. For alignment needed to increase quality, a Plan(s) of Excellence for the year will be developed collaboratively by the P&Q Specialist and the provider. All providers will be required to have at least one Plan of Excellence focused on increasing quality in each year of the Credentialing cycle.
    l. The overall process is designed to be an ongoing, continuous quality improvement process during which the provider will continue to be considered a credentialed CWP provider.

m. If at any time ADMH/DDD determines that a provider is not participating in this process, which is defined as not actively participating in monthly visits, not providing necessary documentation or access to settings, individuals served and/or staff, not timely completing required Plans of Alignment, and/or not providing adequate evidence of their alignment, ADMH/DDD will initiate the Remediation Plan (Attachment BJ processes outlined in the Credentialing Guide.
n. At the end of the Credentialing Year, the P&Q staff will review the Final Report with the Provider to address areas of success and barriers for the next Credentialing cycle.

2. **Credentialing Tool**
   a. The provider will complete the Credentialing Tool for each service that the provider is actively serving CWP participant(s).
   b. The P&Q Specialist will review provided evidence as it relates to each compliance and quality performance indicator and document alignment with each indicator.
   c. The P&Q Specialist will note whether the evidence shows the following:
      - The provider meets the performance indicator.
      - The provider exceeds the performance indicator.
      - Action required by the provider to address lack of full alignment with the performance indicator.
   d. If the provider is not in agreement with the outcomes of the review the provider can complete a written request for a secondary review to be conducted by the CWP P&Q Lead and/or designee. A final decision will be provided to the Agency within 5 business days.
   e. For each compliance and quality performance indicator requiring action, a Plan of Alignment will be developed between the P&Q Staff and Provider Agency during the documentation review meeting.
   f. At least one Plan of Excellence must be developed and adopted each year to improve Provider's practices for Quality assurance with services. New plans of Excellence will be developed at the completion of every Credentialing Cycle.

***Attachment A: Credentialing Schedule of Annual Cycle Activities***
**Schedule of Annual Cycle Activities**
**Getting Started**

**Month One - Onsite Visit**
Laying the Foundation (Year One)
Offsite P&Q Preparation (Subsequent Years)
**Month Two - Onsite Visit**
Targeted Conversations with people served and Focus Groups with staff
Focus - Staffing
**Month Three - Virtual Visit**
Review and documentation of evidence of performance indicators
Focus - Staffing
**Month Four - Onsite Visit**
Targeted Conversations with people served and Focus Groups with staff
**Focus - Communication**
**Month Five - Virtual Visit**

Review and documentation of evidence of performance indicators
Focus - Communication
**Month Six - Onsite Visit**
Targeted Conversations with people served and Focus Groups with staff
Focus - Values
**Month Seven - Virtual Visit**
Review and documentation of evidence of performance indicators
Focus -Values (start)
**Month Eight - Virtual Visit**
Review and documentation of evidence of performance indicators
Focus -Values (finish)
**Month Nine - Onsite Visit**
Targeted Conversations with people served and Focus Groups with staff
Focus -Administrative Functions
**Month Ten - Virtual Visit**
Review and documentation of evidence of performance indicators
Focus -Administrative Functions
**Month Eleven - Offsite**
Wrapping up Plans for Alignment and Excellence
P&Q staff preparing final report
**Month Twelve - Onsite**
Review, Celebration, Planning for Next Year

***Attachment B: Remediation Plan***

**Remediation Plans**

The remediation process will be initiated at such time that Quality Enhancement staff determine that the provider has not made progress toward alignment even after the Quality Enhancement staff have made documented efforts to support the provider to complete their Plans for Alignment. The provider will be considered in jeopardy of losing their "Good Standing" status when the remediation plan is initiated.
The remediation process includes:

1. The P&Q staff will submit a remediation plan to the P&Q lead and/or designee and the CWP Director, for a provider in jeopardy of losing their "Good Standing" status.
    a. The remediation plan will include details as to why the provider is in jeopardy of losing their good standing status, and the specific plans of alignment that need resolution with proposed remediation timelines for completion.
2. P&Q lead and/or designee and the CWP Director will review the remediation plan and recommend to either approve the remediation plan or request adjustments that need to be made before submission to the agency.
    a. If approved, P&Q staff should follow next steps.
    b. If adjustments are noted, P&Q staff will submit revisions to P&Q lead and CWP Director within 3 business days for review.
3. Upon approval of the recommendation, the P&Q staff will provide immediate feedback via email with a read receipt to the provider agency regarding the remediation plan for completion within the timelines provided. If no response has been received, P&Q will follow-up via phone call.
4. If the provider completes the plan within the remediation timelines, they will no longer be in jeopardy of losing their "Good Standing" status.

5. If the provider does NOT complete the remediation plan within the timeline provided, P&Q staff will notify the and CWP Director for review and recommend revocation of the provider's credentials. The provider network manager will be notified of the provider's status.
   a. If the CWP Director recommends revoking the providers credentials, continue to step 6.
   b. If the CWP Director does not recommend revoking the providers credentials, they may request additional documentation or a repeat of step 2-3.
6. The CWP Director will present the recommendation for revoking a provider's credentials to the Associate Commissioner for final review and approval.
   a. If approved, CWP Director will notify Provider Network Manager.
   b. Provider Network Manager will be responsible for notifying the Provider Agency, Appropriate Regional Office Director (CSD}, Office of Certification and CWP Support Coordinator Director.

**Disputing Performance Alignment Decisions**

In the event a provider disagrees with a Quality Enhancement staff's determination that a performance indicator is not in alignment, the Quality Enhancement staff will check with the provider to determine if there is any further evidence that the provider might have that would provide insight as to whether the indicator is or is not in alignment.

If there is no further evidence or the available evidence does not resolve the disagreement. The Quality Enhancement staff will involve at least one additional Quality Enhancement staff to conduct a blind review of the evidence and render a decision. If the provider is still not satisfied, they may appeal to AMDH.

**Please click PDF below to access forms:**

**COMMUNICATIONS VISIT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Communications-Visit-Form.pdf

**CREDENTIALING GUIDE FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Credentialing-Guide.pdf

**CWP ADMINISTRATIVE FUNCTIONS VISIT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Administrative-Functions-Visit.pdf

**CWP PLAN FOR ALIGNMENT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Plan-for-Alignment.pdf

**CWP PLAN FOR EXCELLENCE FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Plan-for-Excellence.pdf

**CWP VALUES VISIT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Values-Visit.pdf

**STAFFING VISIT FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/Staffing-Visit.pdf

## B.5.5 HCBS COMPLIANCE PROCESS FOR CWP

**Responsible Office:** Offices of Certification, Offices of Community Services
**Reference:** 580-5-30-.01 Purpose; 580-5-30-.08 Community Service Provision; 580-5-30-.15 Freedom of Choice
**Effective:** Historical Practice
**Revised:** July 1, 2024

**Purpose/Intent:** To establish a process for approving proposed new settings while also ensuring compliance with HCBS settings regulations.

**HCBS Waivers:** CWP

**Key Terms:**
Office of Certification Administration (OCA)
Executive Director (ED), Temporary Operating Agency (TOA)
Community Services Director (CSD)
Provider Network Manager (PNM)
Office of Systems Management (OSM)

**Procedures:**

1. The Provider Network Manager (PNM) is responsible for processing all new applications for new providers into the CWP provider network.
2. The PNM will complete the following steps before sending the application to the ADMH/DDD Office of Certification Administration (OCA)
    a. Send CWP New Provider Application/ PPQ Assessment to new provider to complete.
    b. Complete a review of the application/assessment.
    c. Score the PPQ Assessment
3. Application and supporting documents are sent to the OCA for quality review and background check request. (See CWP Provider Application)
4. The OCA will review the application. If application package does not meet criteria, package is either returned to applicant for additional information or denied and returned to applicant. Reason 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 responsibilities 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)

5. If application package meets criteria, the OCA will submit the "proposed" setting to the Community Services office for review and recommendations.
6. The Community Services office returns the application with the Application and Setting Review Form, recommendation, and any supporting documentation for all new settings to the OCA.
   a. The Community Services office designee completes Part A and B of the form. If question to Part A of the form is "Yes", the application is not approved and will not be processed further. The Regional Community Service Office will send notification to the OCA. OCA will notify the provider of the outcome of the application.
   b. If question to Part A is "No" the Community Services Office designee will complete Part Band submit to RCS/CSD for review.
7. RCS/CSD and or designee will review and return the application with form and any supporting documentation to the OCA for final review.
   a. 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.
   b. 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.
   c. NOT APPROVED for Certification: If for a new setting or new services, the application is not approved and a letter detailing the denial is returned to the OCA. The OCA is responsible for completing the letter.
8. Life Safety completes a review of only CWP Community Base Residential Settings.
   a. Setting Passes: Life Safety review, documentation/application returned to OCA.
   b. Setting Does Not Pass: Provider given opportunity to correct deficiencies, if possible, or can opt to acquire another property. If provider choose to acquire new property, process start over. Documentation/application returned to OCA.
9. OCA notifies Alabama Medicaid Agency (AMA), Office of DDD Certification CWP P&Q Lead and or designee, and Associate Commissioner of the TOA.
10. The OCA assigns a setting number and notifies Office of Systems Management (OSM), designated Community Services office CSD, DDD Central Office Contract Specialist, Provider Network Manager and CWP Director The PNM will add the provider to the provider network database and notify the CWP Support Coordinator Director identifying the provider as an option for Freedom Choice of Provider.
11. DDD Central Office initiates contract process.
12. PNM will notify DD Support Services to establish the provider in ADIDIS system.
13. Within 6-months of actively providing services, the CWP Planning, and Quality Assurance Specialist will initiate the Credentialing Process for the setting.
14. If no services are provided in the setting at the end of the 6-month certification date, the TOA must be renewed.

# CHAPTER 6
# FINANCIAL MANAGEMENT

## B.6.1 COMMUNITY WAIVER PROGRAM SLOT REALLOCATION PROCESS *(Removed)*

## B.6.2 FINANCIAL MANAGEMENT SERVICES AGENCY TRANSFER

**Responsible Office:** Community Waiver Program
**Reference:** ADMH/DDD Operational Procedures
**Effective:** October 1, 2021
**Revised:** March 22, 2022
**Reviewed:** January 15, 2025

**Statement:** Transferring savings from one self-directed Fiscal Management Service Agent (FMSA) to another FMSA

**Purpose/Intent:** To enable an employer of record to transfer from one FMSA to another one and ensure that an individual's savings accumulated through ADMH/DD's Self-Directed Services delivery system are transferred with them when they change fiscal agents.

**HCBS Waivers:** CWP

**Key Terms:**
Alabama Department of Mental Health/Developmental Disabilities Division (ADMH/DDD)
Person Service Plan (PSP)

**Procedures:**
Due to tax regulations, the transfer from one Financial Management Service Agent (FMSA) can only occur at the beginning of a quarter (January 1, April 1st, July 1st, or October 1st). An employer of record can transfer once per fiscal year.

Due to the reconciliation of the closing account and initiation of the new account process there will be 60-90 days delay in access to budgetary savings while transitioning from one FMSA to another.

**Support Coordinator:**

- The Support Coordinator will complete the transfer form and new referral form for FMSA with the EOR and Waiver Participant.
- The Support Coordinator will submit the transfer form, new referral form, Free Choice of Provider form, and PCP (which includes the PSP) at least 60 days prior to transfer (This form can be submitted prior to the 60-day minimum) to the Support Coordination Supervisor.

**Support Coordination Supervisor:**

- Within 5 business days of submission, the Support Coordination Supervisor reviews the documents to ensure all vital information is included and approves transfer request.
- The Support Coordinator alert staff to submit the transfer form to current FMSA and new referral form to new FMSA.

**Support Coordinator:**

- Within 3 business days, the Support Coordinator submits the approved Transfer Form to the FMSA (at least 45 days prior to transfer date) and submits new referral form to the new FMSA.

**Financial Management Service Agency:**

1. The FMSA is accountable for reviewing all documentation and notifying the Support Coordinator (SC) in case of errors or the need for additional documentation before approval.
2. Once the transfer process is approved and complete, the current FMSA sends a check made out to the Alabama Department of Mental Health. The current FMSA sends a secure email/uploads file that includes the individuals that are transferring services.
3. The DMH DDD CFO will access the secure email/uploaded file to share with the Director of Support Coordination for dissemination to Support Coordination Supervisors.
4. ADMH will deposit the check into the Department's revenue account and make a payment to the accepting FMSA, transferring the funds. The payment should be processed within 3 business days, pending staff attendance, holidays, etc.
5. The accepting FMSA will access the list of transfer records by secure email/file access.
6. If the payment is not received by the accepting FMSA within 7 working days, the FMSA should follow up with the DMH Finance office.

**New Financial Management Service Agency:**

1. Once the transfer is approved and the referral form submitted to the new FMSA by the Support Coordinator, then the enrollment specialist with the FMSA contacts the employer of record.
2. The enrollment specialist will explain the role of the FMSA and assist with paperwork to enroll the individual and EOR into their system.
3. The FMSA will inform the EOR of the "Good to Go date" for their employee.
4. The FMSA will educate the EOR on their electronic verification visit (EVV) system.
5. The FMSA will provide the date for access to budgetary savings and the balance in the savings.

**Employer of Record:**

1. The EOR will begin to use the new FMSA to report time via EVV after the "Good to Go Date," is provided by FMSA.
2. The first day the new FMSA should be used for time reporting is the date provided by the FMSA.

**Please click the link below to access form:**

**CWP FINANCIAL MANAGEMENT SERVICES AGENCY FORM**

https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Financial-Management-Services-Agency.pdf

# CHAPTER 7
# SELF-DIRECTED SERVICES

## B.7.1 SELF-DIRECTED SERVICES REFERRAL PROCESS

**Responsible Office:** Community Waiver Program
**Reference:** ADMH/DDD Operational Procedures
**Effective:** October 1, 2021
**Revised:** March 22, 2022
**Reviewed:** January 15, 2025

**Purpose/Intent:** Provide the process to refer individuals for self-directed services option when individuals elect this option during person-centered planning process.

**HCBS Waivers:** CWP

**Key terms:**
Community Waiver Program (CWP)
Self-Directed Services (SDS)
Alabama Division of Developmental Disabilities Information System (ADIDIS)
Financial Management System Agency (FMSA)
Employer of Record (EOR)
Employer Identification Number (EIN)

**Procedures:**
When a CWP enrollee has a need for one or more services that can be self-directed, and which will be included in their Person-Centered Plan, the Support Coordinator shall follow a consistent process to ensure the CWP enrollee understands their option to self-direct these services.

When a CWP enrollee opts to self-direct one or more services in their Person-Centered Plan, the Support Coordinator will follow a consistent process to ensure the CWP enrollee's free choice to self-direct is document, to ensure the CWP enrollee selects an FMSA from those available, and to ensure the CWP enrollee is timely enrolled in self-directed services. services

**PROCESS FOR SUPPORT COORDINATOR**

1. Hold a meeting with the individual (and his/her legal guardian/family if applicable) to explain the option of self-directed services and how it works.
   a. Use "Deciding if Self-Direction is Right for You" tool to facilitate informed choice about the use of self-direction.
   b. As part of the meeting, provide the individual and with a copy of the SDS Handbook and answer questions detailing the difference between the self-directed service option and traditional service delivery option.

2. If individual (and his/her legal guardian/family if applicable) indicate an interest in the self-directed services option, then the Support Coordinator must:
   a. Ensure the Free Choice form is completed, indicating the individual is selecting SDS. This form should be uploaded to the person's ADIDIS record.

b. Facilitate choice of FMSA by the individual (and his/her legal guardian/family if applicable) and whomever will act as EOR if the individual will not act in this role. Utilize brochure available from each FMSA.
c. Submit the required referral information for the individual to the FMSA chosen and follow-up to ensure formal enrollment into SDS is completed for the individual.

3. The EOR cannot begin to employ individuals until he/she has received a hire date for each worker from the FMSA. (See below). Services performed prior to the hire date will not be reimbursed by waiver funds.

**PROCEDURES FOR FINANCIAL MANAGEMENT SERVICES AGENCY**

1. Once FMSA receives referral from the Support Coordinator, then the FMSA contacts the individual (and his/her legal guardian/family if applicable) and whomever will act as EOR if the individual will not act in this role.

2. FMSA staff will contact the individual (and his/her legal guardian/family if applicable) and whomever will act as EOR if the individual will not act in this role via telephone or email to set up a meeting to discuss the enrollment paperwork and process.

3. FMSA receives documents submitted by the EOR

4. FMSA processes documents and determines if the proposed EOR can obtain an employer identification number (EIN) and become an employer of record (EOR).
   a. If there are problems with the application or it is incomplete, this will delay the process. The FMSA will send an email to the Support Coordinator and/or EOR to request additional information.
   b. Once the EOR has been approved, then they receive notification of their EIN number.

5. EOR identifies employees and connects them with FMSA so they can submit application.

6. FMSA processes employee applications and background checks for potential employees.

7. Once the employee is approved to work, then the FMSA will send an email to the EOR with the employee hire date.

**Please click the link below to access the form:**

**CWP DECIDING IF SELF-DIRECTION IS RIGHT FOR YOU FORM**
https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Decidining-if-Self-Directions-is-right-for-you-Form.pdf

## B.7.2 SELF-DIRECTION BUDGET SAVINGS PLAN & BUDGET SAVINGS ACCOUNT POLICY AND PROCEDURES

**Responsible Office:** Community Waiver Program
**Reference:** CWP Approved Waiver Documents, CWP Self-Directed Services Handbook
**Effective:** March 30, 2023
**Reviewed:** January 15, 2025

**Statement:** The Community Waiver Program allows participants, who opt to self-direct one or more service in their Person-Centered Plan, to establish a Budget Savings Account. CWP participants may use funds accrued in this account to purchase goods and services through use of the CWP service called "Individual-Directed Goods and Services". CWP participants may also use accrued funds in a Budget Savings Account to pay overtime, pre-approved by their Support Coordinator, to their self-direction employee(s), or to cover the cost of additional training for their self-direction employee(s) that the CWP participant/Employer of Record may require.

CWP participants are not required to establish a Budget Savings Account. However, if a CWP participant wishes to use CWP funds as described in the prior paragraph, the CWP participant must establish a Budget Savings Account to do so and the usage of these funds should be documented in the individuals Person-Centered Plan.
Purpose/Intent: Provide rules for CWP Budget Savings Accounts

**HCBS Waivers:** CWP

**Key Terms:**
Community Waiver Program (CWP)
Financial Management Services Agency (FMSA)
Employer of Record (EOR)
Alabama Department of Mental Health/Division of Developmental Disabilities (ADMH/DDD)
Alabama Medicaid Agency (AMA)
Person-Centered Plan (PCP)

**Procedures:**
1. Budget Savings Accounts are Medicaid savings that are generated when the EOR pays a self-direction employee(s) less than the maximum wage rate for one or more services being provided. The maximum wage rate is set by the FMSA based on the maximum Medicaid reimbursement rate for the self-direction service as established by AMA. The FMSA informs the CWP participant/EOR of the minimum and maximum wage rates when decisions are being made about self-directed employee(s) pay rate(s). This process is known as **wage negotiation**. There are trade-offs in paying workers less than the maximum wage rate. For example, the participant may not be able to attract the best quality workers or may have more difficulty keeping workers long-term. The negotiated hourly wage may never be less than whichever of the following is higher: (1) the Alabama state minimum wage or (2) the minimum wage rate allowable for the service as established by ADMH/DDD.
2. The difference between the negotiated wage rate paid plus associated employer costs and the Medicaid reimbursement rate for the self-direction service is the amount that accrues in the CWP participant's Budget Savings Account. For example:

The maximum wage rate of $20 per hour.

- A self-direction employee providing this service is paid $14 per hour plus employer costs of $1.80 per hour for a total of $15.80 per hour.
- $20.00 minus $15.80 = $4.20 total savings per hour of service delivered.
- $4.20 per hour will accrue in the CWP participant's Budget Savings Account for every hour of service provided.

3. If the EOR chooses to pay the maximum wage rate for a service, no funds will accrue in the Budget Savings Account.

4. Budget Savings Accounts are available only to CWP participants who self-direct at least one of their services and supports.

5. **A Budget Savings Plan for the intended use of the budget savings must be developed through the person-centered planning process**, and documented as part of the PCP, identifying overtime, self-direction employee training costs, items and/or additional needed services that are intended for purchase using the Budget Savings Account.
   - This Budget Savings Plan, approved as part of the PCP, may not include planned spending in excess of the annual limit set by ADMH/DDD for each enrollment year.
   - The Plan must provide explicit details about how each planned use of the budget savings will benefit the CWP participant and which specific outcome in the PCP each planned use will support. Purchases must be designed to help the CWP participant become more independent, better manager their disability, become more integrated in their community, be safer, and/or be healthier.
   - In approving a Budget Savings Plan as part of a PCP, ADMH/DDD reserves the right to request additional evaluations or assessments to determine whether a requested use of budget savings is appropriate.
   - The Budget Savings Plan can be revised if the CWP participant's needs change. Any revisions to the Budget Savings Plan are subject to approval as is the case with any change to the PCP.

6. Funds must accrue in the Budget Savings Account before they can be used. Therefore, the CWP participant may accrue a balance in their CWP Budget Savings Account over time, consistent with the total amount authorized in their Budget Savings Plan. Total expenditures from the Budget Savings Plan may not exceed the annual limit set by ADMH/DDD for any enrollment year. Therefore, a CWP participant may not accumulate more than this annual enrollment year limit in their Budget Savings Account at any given time. Balances may be carried over between enrollment years and between ADMH/DDD fiscal years if necessary.

7. FMSAs will not bill ADMH/DDD for amounts that are to accrue to the Budget Savings Account and hold the funds in the FMSA accounts. Instead, the FMSA will bill the actual cost per unit for self-directed Community Waiver Program services (i.e., the actual wage rate plus associated employer costs) and track the remaining unspent amounts in a Budget Savings Account balance sheet or ledger, rather than billing the maximum Medicaid reimbursement rate for the service and holding the

remaining unspent dollars in an FMSA-administered Budget Savings Account. Therefore, savings accrued in the Budget Savings Account remain with AMA until use of funds in the Budget Savings Account is approved by the CWP Support Coordinator (or by the CWP Director, if required in #13 below) based on the Budget Savings Account Plan that is approved as part of the CWP participant's PCP.

8. A participant's CWP Budget Savings Account information (including balance information) is maintained by their Financial Management Services Agency (FMSA). **The Support Coordinator is responsible for regularly checking the balance and sharing this information with the CWP participant/EOR on a monthly basis (confirmed by information reported on the Support Coordination Monthly Service Summary.** If a CWP participant's Budget Savings Account balance reaches 75% of the annual plan year limit set by ADMH/DDD, the CWP Support Coordinator is expected to notify the CWP participant/EOR and advise that the limit is nearly reached. The Support Coordinator shall assist the CWP participant/EOR to move forward with implementing the Budget Savings Plan. If the CWP participant/EOR does not wish to begin expending the funds in the Budget Savings Account, the Support Coordinator shall inform the CWP participant/EOR that the self-direction worker(s) being employed by the CWP participant/EOR can, once the Budget Savings Account cap has been reached, receive a pay increase due to the savings account being fully funded. The CWP Support Coordinator should assist the CWP participant/EOR to work with the FMSA to adjust the self-direction worker(s) wage if this is desired. It should be made clear that a wage increase is not required; but instead, is an option to consider.

9. Purchases made using balance from the Budget Savings Account must follow the CWP federal Waiver requirements. These requirements are explored in greater detail in the CWP Self-Directed Services Handbook. CWP participants and EORs should be aware of these federal requirements that must be followed. ADMH/DDD must follow these requirements in approving Budget Savings Plans and expenditures from Budget Savings Accounts.

10. Procedures for the CWP Participant/Employer of Record: **Prior to making a purchase of an item(s), promising overtime or training reimbursement to a self-directed employee(s), or seeking out additional services** for which the CWP participant/EOR or any other party expects to be paid/reimbursed by the FMSA, the CWP participant/EOR should review the approved Budget Savings Plan, check on the Budget Savings Account balance, and communicate the request to their Support Coordinator to ensure the use of the budget savings can be approved by the Support Coordinator.

11. The Support Coordinator shall review the request and ensure it aligns with the approved Budget Savings Plan, ensure it does not conflict with federal requirements and ensure that there is sufficient funding in the Budget Savings Account to approve the request.

[1] In rare cases, no employer costs may apply to the self-direction worker who is paid the maximum wage rate so the calculated employer costs would accrue to the savings account, if the FMSA is billing Medicaid (AMA) the maximum billable unit rate for the service.

12. If the Support Coordinator determines a planned use of the Budget Savings Account **can be approved**, the Support Coordinator will notify the FMSA that the expenditure has been approved by notating the ADMH ADIDIS system and providing the effective date.
    - Expenditures for overtime must be approved by the Support Coordinator in order to be reimbursed out of their savings accounts. The employer is responsible for sending in a request for overtime to the Support Coordinator prior to services and or hours of units being used. The Support Coordinator shall review the request and ensure it aligns with the approved Budget Savings Plan, ensure it does not conflict with federal requirements and ensure that there is sufficient funding in the Budget Savings Account to approve the request. If the overtime request is approved, the expenditures for overtime will be added in ADIDIS.
    - Expenditure for goods (i.e., an item or items) and/or more/different services must be prior authorized by the Support Coordinator as Individual-Directed Goods and Services (HCPCS code T1999) added to the PCP using the normal process for changing a PCP.
    - Once the FMSA receives the authorization from ADMH, the FMSA will make payment (or provide reimbursement) for the goods and/or services. The FMSA will then claim reimbursement from ADMH for the payment/reimbursement the FMSA made, at which point the funds from the Budget Savings Account will be paid to the FMSA.

13. If the Support Coordinator determines a planned use of the Budget Savings Account cannot be approved by the Support Coordinator, the Support Coordinator will communicate the reason to the CWP participant/EOR:
    - There are **not sufficient funds accrued** in the Budget Savings Account yet to cover the cost of the planned use.
    - The planned use **does not meet federal requirements** as outlined in the Self-Directed Services Handbook
    - The planned use is **not aligned with the approved Budget Savings Plan**. A revision to the Budget Savings Plan must be completed and approved to allow for the planned use.
    - The planned use requires CWP Director approval because the proposed expenditure is **more than 25% higher than the amount approved** in the Budget Savings Account Plan.

    The Support Coordinator will also assist the CWP participant/EOR to revise the Budget Savings Plan and/or submit the request to the CWP Director, if either of these steps is required to gain approval for the planned use.

14. Utilization of Budget Savings Accounts will be reviewed routinely to ensure accrued budget savings are being appropriately authorized and expended, consistent with the approved Budget Savings Plan and federal requirements as outlined in the CWP Self-Directed Services Handbook.

15. When a participant transfers from one FMSA to another, the Budget Savings Account balance as of the date of transfer, the Support Coordinator will add the Budget Savings Account balance to the PCP within 2 months so the amount can be added by Regional Office Fiscal Manager to the electronic record (ADIDIS) system. The balance of the Budget Saving Account will be processed as a service code that is not billable, merely acting as a transfer mechanism for the Budget Savings Account balance information to transfer to the accepting FMSA.

16. If the participant disenrolls from the Community Waiver Program, the FMSA will zero out the accrued Budget Savings Account dollars in their internal balance sheet/ledger system

## B.7.3 MONEY MANAGEMENT FOR INDIVIDUALS SERVED *(Removed)*

# CHAPTER 8
# WAIVER SERVICE GUIDANCE

## B.8.1 HCBS WAIVER SERVICE GUIDANCE ON NURSE DELEGATION FOR MEDICATION ADMINISTRATION

**Responsible Office:** Community Waiver Program
**Reference:** CWP Waiver; Skilled Nursing Assessment & Authorization OG B.8.2
**Effective:** October 15, 2021
**Revised:** March 22, 2022
**Reviewed:** January 15, 2025

**Statement:** The nurse delegation program sets forth certain requirements regarding medication administration.

**Purpose/Intent:** This OG provides an overview of expectations for NDP as it related to Person-centered Planning and medication administration.

**HCBS Waivers:** CWP

Key Terms
Division of Developmental Disabilities (DDD)
Regional Community Services (RCS)
Community Services Director (CSD)
Request for Action (RFA)
Registered Nurse (RN)
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

**Procedures:**

1. The person-centered planning (PCP) team, including the individual and others who know the individual well (e.g., family; guardian) will determine if an individual needs assistance with medication administration that is subject to nurse delegation by a MAS Registered Nurse (RN) and the direct assistance with medication administration by a MAC certified direct support professional (DSP).

2. To assist the PCP team in determining if any supports for medication administration are needed, and if yes, the type of supports needed, the following guidance should be considered:
   a. Nurse delegation by a MAS Nurse (RN/LPN) and the direct assistance with medication administration by a MAC direct support professional (DSP) is not required in the following situations:
      - When the person can self-medicate with verbal reminders, verbal prompts, gestures and/or modeling (if needed) from natural supports or DSPs delivering HCBS Waiver services.
      - Note: In these situations where only verbal reminders, verbal prompts, gestures and/or modeling by the DSP may be needed, the DSP delivering the HCBS Waiver services does not have to be MAC certified. Also note that, if effective for the individual, verbal reminders, verbal prompts, gestures and/or modeling by the DSP can be done virtually using remote audio/video technology as appropriate for the individual.

- When natural supports (E.g., family; other natural supports the person may live with, work with, or spend time with) provide any needed assistance with medication administration including both verbal and physical assistance.
- Note: Paid DSPs should not supplant natural assistance otherwise available to the person.
- Note: If a natural support is being paid to support the person at certain times the following is true:
  - Nurse Delegation applies (and the natural support must be MAC certified) if the natural support is being paid when s/he is assisting the person with medication administration in a way that requires Nurse Delegation (i.e., a way that involves the natural support touching/handling the medication).
  - Nurse Delegation DOES NOT apply (and the natural support must NOT be MAC certified) if the natural support is NOT being paid when s/he is assisting the person with medication administration in a way that requires Nurse Delegation (i.e., a way that involves the natural support touching/handling the medication).

b. If a person has difficulty removing medication from the bubble pack that they come in, consider a different medication system. Options include:
   - A medication administration device that is filled by the pharmacy and that dispenses the appropriate medication(s) and dosage(s) at pre-set times with an alarm to remind the person it is time to take medication.
   - Note: These devices sometimes include technology to monitor if the medication has been removed from the device at the appropriate time, which further ensures the person takes their medication timely.
   - Note: A DSP or natural support can also provide verbal reminders, verbal prompts, gestures and/or modeling (if needed) and the DSP does not have to be MAC certified, nor does nurse delegation apply.
   - Note: These devices cannot be filled with controlled substances so if a person takes a controlled substance, this would not be an option for that particular medication.
   - Individual dose packets with tear-off seam similar to individual dose packets of over-the-counter drugs (E.g., Advil, Tylenol).
c. If a person needs assistance from a Self-Direction DSP with medication administration that requires Nurse Delegation (i.e., a way that involves the Self-Direction DSP touching/handling the medication), the Self-Direction DSP needs to be MAC certified and supervised by an RN/LPN who has gone through MAS training. The RN/LPN's involvement is covered through a Skilled Nursing authorization.
d. Annually, as part of the person-centered planning process, for any HCBS Waiver service enrollee who is not self-administering medication, the PCP team should give consideration to the HCBS Waiver service enrollee's ability and desire to learn to self-medicate and how supports to encourage and train the HCBS Waiver service enrollee to self-medicate can be incorporated into the PCP.
e. A Medication Self-Administration Assessment Form (NDP-5) is only done if the PCP team concludes a person may need a MAC-certified DSP to physically handle and/or administer medication to a HCBS Waiver service enrollee. This Assessment must be completed by a MAS trained RN or LPN.

f. A comprehensive assessment is only completed if Skilled Nursing is being authorized to include delegation as a service or as a component of another service. A comprehensive Assessment may be initiated by the MAS LPN and verified by the MAS RN.

## B.8.2 SKILLED NURSING – ASSESSMENT & AUTHORIZATION

**Responsible Office:** Community Waiver Program
**Reference:** Request for Regional Action (RFA) Instructions
**Effective:** October 29, 2021
**Revised:** March 31, 2022
**Reviewed:** January 15, 2025

**Statement:** Skilled Nursing services provided to persons receiving Community Waiver services prevent unnecessary institutionalization (e.g., in hospitals or nursing homes) and contribute to increased independent living and community integration.

**Purpose/Intent:** Skilled Nursing services may be authorized via the Community Waiver Program, with provision of a verified physician's order and completion of an assessment by the RCS RN. Skilled Nursing services are available only in enrollment Groups 2 and 3.

**HCBS Waivers:** CWP

**Key Terms:**
Community Services Director (CSD)
Request for Action (RFA)
Registered Nurse (RN)
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

**Procedures:**
1. Skilled Nursing services are to be requested via the RFA process (see CWP RFA).

2. To authorize Skilled Nursing as a service provided via the Community Waiver Program, the following are required:
   a. A physician's order based on medical necessity (reviewed and confirmed by the RCS RN); and
   b. An assessment, conducted by the RCS RN, to determine:
      - If the services may be safely and effectively provided in the home or community (the places where the individual spends or intends to spend time and needs to receive the service while at these places);
      - If the service need is covered in that it is for either or both of the following:
        - Training and supervision provided to natural caregivers and/or direct support professionals (self-direction or agency workers) related to medical care and/or assistance with ordinarily self-administered medications; or
        - Nursing procedures that meet the person's health needs as ordered by a physician.
        - The specific type of Skilled Nursing service and the amount of time needed. For example:
          - ✓ Injections - 30 minutes for preparation, administration, and documentation;
          - ✓ Wound Care – One hour for preparation, assessment, performance, and documentation;

- ✓ Tube Feedings – One hour for preparation, assessment, administration, post-feeding assessment and documentation.

3. Of the above two ways to provide this service (e.g., training to caregivers vs. physician-ordered nursing procedures), the Regional Office RN will recommend the most cost-effective option based on their assessment for the meeting the waiver participant's needs through this service, ensuring consistency with the physician's order in all cases.

4. The need for continued medically necessary Skilled Nursing services must be documented by a new physician's order no less than every year at the time of the annual redetermination.

5. A reassessment by the RCS RN, based on the same information outlined in 2.b., above, must occur at least annually.

6. Note that this service is not available to individuals during the time they are receiving residential services (Community-Based Residential Services; Adult Family Home; Supported Living), including training and supervision of direct support professionals working in any of these residential services (Supported Living; Adult Family Home; Community-Based Residential Services) because payment for the nursing services, including nurse supervision, is already included in the rate paid for those services.

7. For individuals living with natural caregivers, the individual must require skilled nursing training, supervision and/or care which exceeds the caregiver's ability to care for the recipient. If a caregiver has been providing care that is otherwise proposed to be provided through Skilled Nursing services, there must be a negative change in the individual's condition and/or the caregiver's status that has occurred to warrant supplanting the caregiver's role by authorizing Skilled Nursing services. The negative change could also be an imminent negative change that service is authorized to prevent; but negative change must be imminent.

8. Skilled Nursing under the Community Waiver Program is not available to enrollees under the age of 21 because Private Duty Nursing is covered under the State Plan EPSDT services.

9. The CWP SCS has 3 business days to submit the RFA and supporting documentation to the RSC RN.

10. Upon receiving an RFA, the RCS RN will review the RFA and supporting documentation. The RCS RN will complete Skilled Nursing Assessment and submit their assessment results and recommendations to the CWP Support Coordinator Supervisor within 20 business days of receiving RFA. The CWP Support Coordinator Supervisor will make the final authorization decision within 3 business days (see OG B.3.3 Request for Action (RFA) Instructions).

## B.8.3 NON-CONTRACTED CWP WAIVER SERVICES *(Removed)*

## B.8.4 EXTERNAL WAIVER TRANSFERS TO CWP

**Responsible Office:** Offices of Support Coordination
**Reference:** 1915c Home and Community Based Community Waiver Program (CWP)
**Effective:** March 13, 2023

**Statement:** Policy and Procedure for Transfers to the CWP

**Purpose/Intent:** Establishes Policy/Procedures for waiver transfers from another waiver operated by other operating agency to the CWP.

**HCBS Waivers:** CWP

**Key Terms:**
Alabama Department of Senior Services (ADSS)
Alabama Department of Rehabilitation Services (ADRS)
Alabama Medicaid Agency (AMA)

**Procedures:**

1. All participants interested in a transfer from another waiver program must be on the waiting list for ADMH.
2. The Waiting List Coordinator:
   a. Identifies applicant 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 Waiver placement of each approved applicant via the Interchange.
      - If the review of eligibility reveals a person is on another waiver program, that information will be entered into ADIDIS in a note and the Support Coordinator informed.
   d. The Support Coordination will provide outreach to the family/applicant to inform them of the CWP waiver services to determine if the applicant is interested in transferring.
4. If the applicant expresses interest, the Support coordinator must determine any extenuating circumstances supporting the need for the transfer.
5. The want/desire for employment related services will be the determining factor supporting the transfer and should be approved by the CWP coordinator or his designee. The support coordinator should follow the procedures below when transferring from another waiver program:
   a. 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.
   b. 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.
   c. The transferring case manager/support coordinator should close the case on the last working day of the month.

d. The receiving case manager/support coordinator should process the admission to the receiving waiver on the first day of the following month.
e. 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.

# LIST OF FORMS TABLE FOR CWP WAIVER

| Form Reference | Form Title/Links |
|---|---|
| **Operational Guideline B.1.1** | **INITIAL CONTACT INFORMATION FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Initial-Contact-Information-Form-CWP.pdf |
| **Operational Guideline B.2.2** | **DISSATISFACTION OF SERVICES GRIEVANCE FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Dissatisfaction-of-Services-Grievance-Form-CWP.pdf |
| **Operational Guideline B.3.3** | **REQUEST FOR REGIONAL ACTION & INSTRUCTIONS FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Request-for-Regional-Action-and-Instructions-CWP.pdf |
| **Operational Guideline B.3.5** | **INDIVIDUAL EXPERIENCE ASSESSMENT SURVEY FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Individual-Experience-Assessment-Survey-CWP.pdf |
| **Operational Guideline B. 3.6** | **FREEDOM OF CHOICE FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Freedom-of-Choice-Form-CWP.pdf |
| **Operational Guideline B.3.6** | **ANNUAL PHYSICAL EXAMINATION FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Annual-Physical-Examination-Form-CWP.pdf |
| **Operational Guideline B. 3.7** | **CWP REQUEST FOR PROPOSAL (RFP) TO PROVIDER WAIVER SERVICES FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Request-for-Proposal-to-Provider-Waiver-Services.pdf |
| **Operational Guideline B.3.8** | **REQUEST FOR CSS CONSULTATION FOR CWP PARTICIPANT FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Request-for-CSS-Consultation-for-CWP-Participant-Form.pdf |
| **Operational Guideline B.4.3** | **RENT RESIDENCY AGREEMENT GUIDELINES FORM** https://mh.alabama.gov/wp-content/uploads/2025/05/Rent-Residency-Guidelines.pdf |

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|---|---|
| **Operational Guideline B.5.1** | **CWP PROVIDER APPLICATION FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Provider-Application-Form.pdf |
| **Operational Guideline B.5.1** | **CWP SERVICE PROPOSAL FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Service-Proposal.pdf |
| **Operational Guideline B.5.1** | **PREFERRED PROVIDER QUALIFICATIONS (PPQ) INFORMATION REQUEST FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Preferred-Provider-Qualifications-Information-Request.pdf |
| **Operational Guideline B.5.4** | **COMMUNICATIONS VISIT FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Communications-Visit-Form.pdf |
| **Operational Guideline B.5.4** | **CREDENTIALING GUIDE FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Credentialing-Guide.pdf |
| **Operational Guideline B.5.4** | **CWP ADMINISTRATIVE FUNCTIONS VISIT FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Administrative-Functions-Visit.pdf |
| **Operational Guideline B.5.4** | **CWP PLAN FOR ALIGNMENT FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Plan-for-Alignment.pdf |
| **Operational Guideline B.5.4** | **CWP PLAN FOR EXCELLENCE FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Plan-for-Excellence.pdf |
| **Operational Guideline B.5.4** | **CWP VALUES VISIT FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Values-Visit.pdf |
| **Operational Guideline B.5.4** | **STAFFING VISIT FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/Staffing-Visit.pdf |
| **Operational Guideline B.6.2** | **CWP FINANCIAL MANAGEMENT SERVICES AGENCY FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Financial-Management-Services-Agency.pdf |
| **Operational Guideline B.7.1** | **CWP DECIDING IF SELF-DIRECTION IS RIGHT FOR YOU FORM**<br>https://mh.alabama.gov/wp-content/uploads/2025/05/CWP-Decidining-if-Self-Directions-is-right-for-you-Form.pdf |

# *Glossary*

**310 Authority for Targeted Support Coordination (TSC)** - *Agency housing services formerly known as case management; assists waiver recipient to access necessary services and benefits.*

**Adaptive Behavior Scale (ABS)** - *A standardized measure of adaptive functioning sometimes utilized in addition to the ICAP.*

**ADMH DDD Support Home** - *A state funded, community based residential setting that provides 24-hour living arrangement, with supervision, for up to three participants to live in a home owned or operated by a certified ADMH-DDD Provider. Larger settings, serving more than three participants may be considered upon review by the ADMH-DDD Office of Certification, ADMH-DDD Community Services Office, and final approval by the ADMH-DDD Associate Commissioner and ADMH-DDD Commissioner.*

**Adverse Action** - *A decision that negatively impacts the applicant.*

**Alabama Department of Developmental Disabilities Information Management System (DDD IMS)** - *Information management system used by ADMH-DDD to store and share data.*

**Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DD)** - *ADMH-DD provides a comprehensive array of services and supports to participants with intellectual disabilities and their families in the state through contractual arrangements with community agencies and self-directed participants.*

**Alabama Department of Rehabilitation Services (ADRS)** - *State of Alabama Independent Living Waiver (SAIL) is operated by ADRS. Sail Waiver: provides services to disabled adults 18 years of age or older who have specific medical diagnoses and who would otherwise qualify for care in a nursing care facility.*

**Alabama Department of Senior Services (ADSS)** - *Waivers operated by ADSS include: Elderly & Disabled (E&D), Alabama Community Transition (ACT), and Technology Assisted Waiver for Adults (TAW). E&D Waiver: The Elderly and Disabled Waiver program provides services to the elderly and participants with disabilities at risk for nursing facility placement. ACT: The ACT waiver provides services to participants with disabilities or long-term illnesses who live in a nursing facility and wish to transition to a home or community setting. TAW: The TA waiver provides services to participants age 21 or older with complex skilled medical conditions who are ventilator dependent or have a tracheostomy and who would otherwise require care in a long-term care setting to remain in the community.*

**Alabama Division of Intellectual Disabilities Information System (ADIDIS)** - *Information management system used by ADMH-DDD to store and share data.*

**Alabama Medicaid Agency (AMA) -** *State of Alabama oversight agency for the provision of Medicaid services.*

**AMA Waiver Program Manager** *- This position at the Alabama Medicaid Agency (AMA) oversees the program's operations, ensuring access to care, supporting independent living, and promoting community integration for people with intellectual/developmental disabilities.*

**Appeal** *- A formal request to review a determination of adverse action made on one of the HCBS ID Waiver programs.*

**Appeal Packet** *- the supporting documents provided to Appeal review panel members during an appeal through Informal Conference with ADMH-DDD.*

**Appeal Request Form (ARF) -** *Document used by participants and their families to request an appeal or informal conference with ADMH to appeal adverse action.*

**Appeals Process for Adverse Actions -** *the procedures for processing an appeal through an Informal Conference with ADMH-DDD following a denial of waiver eligibility or services, known as an adverse action.*

**Behavior Program Review Committee BPRC) -** *a multidisciplinary group of professionals who play a crucial role in ensuring that Behavior Support Plans (BSPs) adhere to ethical standards, best practices, and HCBS guidelines. The BPRC specifically reviews BSPs containing intensive or restrictive interventions.*

**Behavioral & Psychological Evaluator (BPE) -** *Regional Community Services staff with specialized behavioral and psychological credentials.*

**Behavioral Services Procedural Guidelines (BSPG) -** *Established as the minimum set of standards, the BSPG provide information and guidance for the development and implementation of behavioral services and apply to all providers and recipients of Positive Behavior Support services though the ADMH-DDD HCBS Waiver Programs for individuals with intellectual disabilities.*

**Benefits Planning and Reporting -** *Benefits Planning and Reporting Services enable participants to work while maintaining needed Social Security and medical benefits*.

**Behavior Program Review Committee (BPRC) -** *A multidisciplinary group of professionals who play a crucial role in ensuring that Behavior Support Plans (BSPs) adhere to ethical standards, best practices, and HCBS guidelines. The BPRC specifically reviews BSPs containing intensive or restrictive interventions.*

**Behavior Support Plan (BSP) -** *Also referred to as a BSP, the Behavior Support Plan is a plan that assists a participant in building positive behaviors to replace or reduce challenging/dangerous*

*behavior(s). Designed to complement the Person- Centered Plan (PCP) process, a BSP is developed to address behaviors identified as barriers to the individual's attainment of goals listed in the PCP.*

**Board-Certified Behavior Analyst (BCBA) -** *Professional certified in applied behavioral analysis by the Behavior Analyst Certification Board.*

**Call Center (CC) -** *The Call Center is the centralized point of contact to initiate and ensure the request of referrals will be expedited.*

**Certification Tool -** *The Certification Tool is an Excel document that contains all the Values, Requirements, and Elements. The Certification Specialist uses evidence from document reviews, conversations or focus groups with people receiving services, conversations or focus groups with staff, conversations with provider leadership, and site visits to complete the tool.*

**Certified Findings Quality Improvement Plan of Action -** *The tool used by Certification to report deficiencies identified during the site review. It is also a Plan of Action created by Certification staff and implemented by the provider. Currently replaced.*

**Centers for Medicare and Medicaid Standards (CMS)** - *The federal agency that provides health coverage to more than 160 million through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. CMS works in partnership with the entire health care community to improve quality, equity and outcomes in the health care system.*

**Community Services Director (CSD)** - *Director of each ADMD-DDD Community Services Regional office.*

**Community Waiver Program (CWP)** - *An HCBS waiver program that is targeted to serve persons with intellectual disabilities not currently receiving services through a current Intellectual Disabilities (ID) and Living at Home (LAH) Home Community-Based Services waivers. The CWP waiver program is targeted to serve persons with intellectual disabilities currently on the waiting list for waiver services if they reside in one of the 11 counties that the waiver program is serving.*

**Comprehensive Support Services Teams (CSS)** - *Specialized behavioral team housed in the Office of Behavioral and Psychological Services. Comprised of five regionally based teams, CSS services include behavioral supports consultation, crisis intervention, specialized evaluations, as well as psychiatric, medical, and dental consultation services.*

**Continuous Quality Improvement (CQI)** - *Continuous Quality Improvement (CQI) is a systematic, cyclical process of identifying opportunities and making incremental improvements to processes, systems, products, or services to enhance efficiency, quality, and value delivery.*

**Contractor** - *Any entity having a direct contract with the Alabama Department of Mental Health ADMH/DDD to provide services to participants with intellectual and/or developmental disabilities. The contractor is responsible for the quality performance of ALL its subcontractors.*

**CWP Planning & Quality Assurance Specialist** - *P&Q Specialist is responsible for conducting compliance reviews in accordance with the Alabama Department of Mental Health (ADMH) standards and monitoring the service delivery of all contract providers funded through the Medicaid Waiver Program. This role ensures that providers adhere to regulatory requirements and deliver quality services in alignment with program guidelines.*

**Decertification** - *To withdraw or revoke the certification of certified providers, typically occurring when the provider fails to consistently meet standards, including but not limited to, the receipt of provisional certification status by a program at least twice within on 12-month period.*

**Department of Public Health (ADPH)** - *The Alabama Department of Public Health provides letters of support for qualified National Interest Waiver (NIW) applicants. To qualify, applicants must satisfy the requirements enumerated in Alabama's NIW guidelines and procedures. The guidelines contain an abbreviated procedure for requesting NIW letters of support for physicians who are already practicing in the state under a J-1 waiver. Other foreign-trained physicians who have not previously submitted J-1 waiver documents to the state are required to fully comply with all NIW documentation requirements.*

**Direct Support Professionals (DSP)** - *Professionals who work directly with participants who have disabilities or special needs. DSPs provide support and assistance with daily living tasks such as personal care, and transportation.*

**Discovery** - *A period of exploration to explore skills, interest, talents and abilities.*

**Division Developmental Disabilities Information Management System (DDD IMS)** - *Information management system used by ADMH-DDD to store and share data.*

**Due Process Medicaid Review (Fair Hearing)** - *A hearing with the Alabama Medicaid Agency heard before an administrative law judge, as part of the HCBS Waiver programs formal appeals process.*

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** - *EPSDT is a child health program in Medicaid designed to provide comprehensive preventative health care for children and adolescents, including preventative health, dental, mental health, and other specialty services*

**Elements (Certification Tool)** - *Under each Requirement in the Certification Tool are several Elements. These are used to determine whether the provider is meeting the overall Requirement. The term Elements has replaced the use of the term "Probes" from the previous ADMH-DDD Certification Tool.*

**Electronic Visit Verification (EVV)** - *A method used to verify service provision that validates date, time, location, and the name of the professional providing services.*

**Elements (Certification Tool)** - *Under each Requirement in the Certification Tool are several Elements. These are used to determine whether the provider is meeting the overall Requirement. The term Elements has replaced the use of the term "Probes" from the previous ADMH-DDD Certification Tool.*

Employer of Record (EOR): *Person who serves as the legal employer of workers and responsible for oversight of SDS with in the home. The EOR can be a representative the waiver participant has appointed to serve as employer on their behalf, or the waiver participant themselves. The EOR is responsible for oversight of all employees and reviewing and approving each worker's timesheets before they are sent to the FMSA for payment.*

**Employment Small Group Service** - *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 participant 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.*

**Employment Transportation Service** - *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.*

**Employer Identification Number (EIN)** - *Unique 9-digit number assigned to a business or participant by the IRS.*

**Employer of Record (EOR)** - *Person who serves as the legal employer of workers and responsible for oversight of SDS with in the home. The EOR can be a representative the waiver participant has appointed to serve as employer on their behalf, or the waiver participant themselves. The EOR is responsible for oversight of all employees and reviewing and approving each worker's timesheets before they are sent to the FMSA for payment.*

**Environmental Accessibility Adaptations (EAA)** - *The physical adaptations to the home, required by the participant's plan of care, which are necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home and without which, the recipient would require institutionalization.*

**EVV (Electronic Visit Verification)** - *A method used to verify service provision that validates date, time, location, and the name of the professional providing services.*

**Fair Hearing** - *The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. Appendix F specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.*

**Fair Market Rent (FMR)** - *An amount determined each fiscal year to set payment standards for federal housing assistance programs in Alabama. To determine FMR in a given county, visit https://www.rentdata.org/states/alabama/2022*

**Financial Management System Agency (FMSA)** - *The agency that handles administrative responsibilities on behalf of the employer for waiver participants that choose SDS. The agency issues paychecks to a participant's workers, pays all required taxes, and helps participants manage their budgets*.

**Free Choice of Provider (FCOP) -** *The process that ensures the waiver recipient has the right to choose his/her provider for each service without coercion or issues with the selected provider.*

**Functional Behavior Assessment (FBA)** - *An assessment that identifies observable and measurable, operationally defined behaviors of concern; identifies events and situations which predict when the target behavior will and will not occur; and identifies what functions the behaviors appear to serve as well as outlines replacement behaviors.*

**Grievance** - *A grievance can be defined as an expression of dissatisfaction or complaint related to the State's or a provider's compliance with the person-center planning and service plan requirements at § 441.301(c)(1) through (3) and the HCBS settings requirements at § 441.301(c)(4) through (6), regardless of whether the beneficiary requests that remedial action be taken to address the area of dissatisfaction or complaint. This process is different from when an participant chooses to file a request for an appeal if services are denied, terminated, or reduced and it is not a pre-requisite or substitute for a request for a Fair Hearing. It is a waiver participant's right to have their satisfaction with supports and services reviewed at intake and least annually or upon request.*

**Home and Community Based Services (HCBS)** - *The Home and Community-Based Services regulations set forth requirements under which states may provide home and community-based long-term services and supports. These services are provided via HCBS waiver programs.*

**Home and Community Based Settings Rule (HCBS)** - *The Centers for Medicare and Medicaid Services (CMS) issued the HCBS Settings Rule in 2014 to require every state ensures services delivered to participants with disabilities living in the community meet minimum standards for integration, access to community life, choice, autonomy, and other important protections.*

**Human Rights Committee (HRC)** - *A Human Rights Committee is a group of people with a broad range of backgrounds and life experiences who are charged with the responsibility of promoting and protecting the rights of participants whom the agency serves.*

**Incident Prevention Management System (IPMS)** - *System that serves to promote an environment free from harm. It defines a system for reporting and appropriately responding to incidents with waiver recipients.*

**Informal Conference (Appeals)** - *A conference as part of the appeals process within the ADMH-DDD.*

**Information Management System (IMS)** - *Information management system used by ADMH-DDD to store and share data.*

**Individual Experience Assessment (IEA) -** *The approved assessment that describes and measures the participant's experience with ADMH HCBS Waiver services.*

**Individualized Plan for Employment (IPE)** - *An Individualized Plan for Employment (IPE) is an employment plan used by State VR agencies. The IPE is developed by an individual and a State VR agency after the State VR agency determines that the individual is eligible for VR services. IPE is a description of the specific employment outcome that is chosen by the eligible individual that is consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, career interests, and informed choice.*

**Intellectual Disabilities (ID) Waiver** - *Type of Home and Community Based waiver provided by ADMH-DDD for persons with Intellectual Disabilities providing a variety of long-term services and supports.*

**Intelligence Quotient) (IQ)** - *A score that represents a participant's overall cognitive ability, derived from an objective assessment of intelligence.*

**Interchange** - *The secure site which gives providers, clerks and billing agents the opportunity to view Claim and Prior Authorization status as well as Eligibility Verification inquiries and to upload and download standard X12 and NCPDP transactions*.

**Interchange (Medicaid Management Information System (MMIS)** - *MMIS is used to determine if a waiver recipient meets eligibility criteria for the waiver based upon functional abilities.*

**Interdisciplinary Team (IDT) -** *An IDT is a group of persons with diverse expertise who work together to address the unique needs of individuals in a care setting. IDTs typically hold regular meetings to discuss a waiver individual's needs, progress, and challenges. The team may include nursing professionals, residential care staff, family members, support coordinators, and others.*

**Inventory for Client and Agency Planning (ICAP)** - *Adaptive Assessment used to determine if a participant meets eligibility criteria for the waiver based upon functional abilities.*

**Job Coach Service** - *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.*

**Job Developer Service** - *A distinct service that is utilized to help a participant 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.*

**Legal Representative** - *Legal Representative is someone who is legally authorized under state and federal law to make decisions on behalf of a beneficiary.*

**Level of Care (LOC)** - *Level of Care is the intensity and type of medical or long-term care services a person needs, determined by their health conditions, functional capabilities, and personal support needs. Level of Care requires documentation of a full scale IQ below 70; a diagnosis of Intellectual Disabilities with an age of onset prior to age 18, and significant functional limitations in three (3) of six (6) areas of life activities (Self Care; Receptive and Expressive Language; Learning; Mobility; Self Direction; Capacity for Independent Living).*

**LOC (Level of Care) Document** - *Document completed by RCS staff indicating level of care eligibility for continued services. This form ensures the waiver participant maintains criteria for waiver eligibility, including that the participant meets the ID/ICF Level of Care requirement*

**Long Term Care Notification for Redetermination (LTC-2)** - *A Medicaid form used in annual redeterminations as well as to document waiver discharges, terminations, and/or death.*

**Living at Home) Waiver (LAH)** - *Type of HCBS waiver provided by ADMH-DDD providing a variety of services and supports for waiver recipients who reside at home.*

**National Provider Identifier (NPI)** - *A unique 10-digit code that is used to identify medical professionals and healthcare providers.*

**Natural Supports** - *Family, friends, and or community resources such as local organizations, clubs, places of worship, schools, or other places where new and existing relationships can be built and facilitated outside of the organization that is important to the participant.*

**Non-Waiver HCBS Provider** - *A provider that does not provide HCBS Medicaid Waiver Services.*

**Non-Waiver HCBS Setting** - *A setting that does not provide HCBS Waiver Services and does not receive HCBS Waiver funding.*

**Office of Certification Administration** - *The Office that receives and processes all applications for services and supports at the Alabama Department of Mental Health.*

**Office of Psychological and Behavioral Services (OPBS) -** *OPBS was established within ADMH-DDD to provide behavioral education, training, and professional support to the IDD community through the service of five regionally-based comprehensive support services teams. OPBS coordinates the implementation, training, and monitoring of behavioral and supports and services in the HCBS community agencies.*

**Office of Waiver Appeals (OWA)** - *office within ADMH- DDD in which appeals are received, processed, and reviewed for decision of denied services for recipients who are on the ID, LAH, or CWP waivers, including denial of waiver eligibility.*

**Participant Eligible** - *Participants eligible with a diagnosis of Intellectual Disabilities (ID); participants who do not require intensive behavioral or medical interventions. Participants assessed by Community Services Behavioral and Psychological Evaluator and the Community Services Registered Nurse as being appropriate for Support Home Services.*

**People** - *Individuals who receive waiver services through the Alabama Medicaid Waivers.*

**Individualized Education Program (IEP) -** *Documentation from a participant's school outlining results of psychometric testing administered and educational supports being provided by the local School System.*

**Participants Eligible -** *Participants eligible with a diagnosis of Intellectual Disabilities (ID); participants who do not require intensive behavioral or medical interventions. Participants assessed by Community Services Behavioral and Psychological Evaluator and the Community Services Registered Nurse as being appropriate for Support Home Services.*

**Participants eligible for services provided by CSS Teams** - *Participants enrolled in ID, LAH, or CWP waiver programs; and who are experiencing behavioral challenges which require diagnostic or treatment consultation; and whose experienced behavioral challenges are significant, including crisis, and/or emergency situations that may lead to a participant experiencing psychiatric hospital admission, incarceration, or challenges to maintaining community living.*

**Personal Emergency Response System (PERS)** - A service that provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate assistance in the event of a physical, emotional, or environmental emergency. PERS may also include cellular telephone service used when a conventional PERS is less cost-effective or is not feasible.

**Person-Centered Plan (PCP)** - A plan that reflects the services and supports that are important for the waiver recipient to meet the needs identified through an assessment of functional need,

as well as what is important to the waiver recipient with regard to preferences for delivery of such services and supports.

**Plans for Alignment** - *The Plans for Alignment are part of the Certification Tool and contain a list of all Requirements that "Need Action" in the tool. The Certification Specialist and provider will strategize action steps for the Plans for Alignment during the Closing Meeting of the Certification Review.*

**POA (Plan of Action)** - *A document that lists what steps must be taken to achieve a specific goal. It breaks down the goal into actionable steps that can be easily followed and tracked.*

**POC (Service Page--formerly POC)** - *Document that outlines all services to be added or terminated for a participant.*

**Positive Behavior Supports (PBS)** - *A set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a waiver recipient's environment and fostering a positive environment where participants can thrive.*

**Preferred Provider Qualifications (PPQ) -** *Preferred Provider Qualification is a rating system used to assess the suitability of a provider to deliver Community Waiver Program (CWP) services. The qualification is determined by a score ranging from 2 to 5, based on the strength of specific indicators that predict the provider's ability to effectively deliver services. A higher score reflects a stronger capability to meet the program's service delivery requirements.*

**Pre-Vocational Services** - *A generalized service that helps a participant progress down a defined pathway to employment. Only participants interested in integrated and competitive employment should receive this service.*

**Provider** - *The owner and operator of the residential home.*

**Provider Network Manager (PNM)** - *This staff person recruits and develops the contracted provider network that support participant choice, dignity, and fosters full participation in communities.*

**Provider-owned or controlled setting** - *A provider-owned or controlled setting is a physical setting in which the individual resides*

a. *that is owned, co-owned, leased or rented by a provider of HCBS providing services onsite; or*
b. *that is owned, co-owned, leased or rented by a third party that has a direct or indirect financial relationship with a provider of HCBS.*
c. *in which receipt of support services is limited to a specific provider while living at the site; or*
d. *for which occupancy/continued occupancy is contingent upon continuing receipt of support services from the provider.*

*A setting that meets this definition is a provider-owned or controlled setting, regardless of whether a lease/rent or residency agreement is signed by the individual, and guardian if applicable. The existence of a residency agreement does not transfer ownership or control from the provider to the individual and/or guardian.*

**Provisional (1-Year) Certification** - *New provider organizations are eligible for a Provisional Certification term of one-year by going through a Certification Review. Once the year is complete, they will undergo one more Provisional Certification Review for another one-year Certification period. Thereafter, they will no longer be eligible for Provisional Certification.*

**Provisional Status** - *This is a temporary condition, usually a specified timeframe, given to providers to correct noncompliant deficits identified during a site review, which allows an agency to implement a quality improvement plan of action and bring the deficits back into compliance.*

**Qualified Developmental Disabilities Professionals (QDDP)** - *The QDDP is a Developmental Disability professional with at least one year of experience working directly with participants with intellectual disabilities, holds a bachelor's degree in a human services field, and has completed a series of required training as referenced in applicable ADMH-DDD regulations and guidelines.*

**Quality Improvement Plan (QIP)** - *A community agency's plan to assist with the improvement of the quality of supports and services provided to waiver recipients.*

**Regional Community Services (RCS)** - *Regional offices of the ADMH-DDD service delivery system.*

**Regional Community Services Office Staff** - *Includes all professional staff housed within each Regional Community Services office*

**Regional Fiscal Manager (RFM) -** *Fiscal manager within each Regional Community Services office*

**Region Office (RO)** - *Regional offices of the ADMH-DDD service delivery system.*

**Registered Nurse (RN) -** *Regional Community Services Registered Nurse staff member.*

**Replacement Setting** - *A setting used to replace a current ADMH/DDD certified setting.*

**Request for Proposal (RFP)** - *Document submitted to request consideration to provide services.*

**Requirements (Certification Tool)** - *Under each Value in the Certification Tool are several Requirements, which are used to determine whether a provider is meeting required Performance Indicators and Alabama Code. The term Requirements has replaced the use of the term "Indicators" from the previous ADMH-DDD Certification Tool.*

**Request for Action (RFA)** - *Document submitted to request all changes to an participant's plan of care; DDD IMS (Division of Developmental Disabilities Information Management System).*

**Reserved Capacity Slots** - *Reserve capacity slots are available to enroll any functionally and financially eligible individual into this waiver, who lives in the demonstration area where this waiver is operating, when that individual makes him/herself known to ADMH/DDD and is determined to meet the definition of a reserve capacity category.*

**Residency Agreement** - *The document that evidences the complete terms under which parties have agreed as attested by their signature.*

**Residential Home** - *The provider owned, and controlled setting chosen by the individual to receive HCBS Waiver services.*

**Residential Staffing Tool -** *Fiscal management tool used for calculating residential daily rates including base rates, approved special level staffing rates, behavioral rates, and medical rates*

**Room and Board** - *The cost for the provision of meals, a unit or room to sleep, laundry, basic utilities, housekeeping, pest control, maintenance, insurance, etc., which reflects a proportional allocation of which are shared expenses with other residents/tenants in the same home*.

**Review Panel** - *Review Panel is a group of professionals/experts designated to assess and analyze gathered information. The panel's role is to provide impartial and objective feedback, ensuring that the evaluation process is thorough, fair, and based on the relevant data.*

**Self-Directed Liaison (SDL)** - *A staff person who provides SDS application packet explanation of the procedures.*

**Self-Directed Services (SDS)** - *A waiver service delivery option that allows participants with disabilities to have more control over the services and supports they receive. With self-direction, they can chose who provides the service, as well as how, when, and where services are provided.*

**Special Review Committee for CWP (SRC)** - *The CWP Special Review Committee (SRC) typically handles complex cases for participants seeking 1915(c) enrollment in CWP Group #4, where the participant meets the institutional level of care but has assessed needs that cannot be met through the services available in the enrollment group, they would otherwise be eligible for based on their age. The SRC's purpose is to ensure that decisions align with established guidelines, policies, and prioritize the best interests of the participants involved.*

**Specialized Medical Equipment/Supplies (SMS)** - *Supplies specified in the plan of care and are necessary to maintain the participant's health, safety and welfare, prevent further deterioration of a condition, or increase a participant's ability to perform activities of daily living. Specialized medical supplies are supplies that address the participant's physical health and any ancillary supplies.*

**Standalone Subcontractor** - *A sub-contractor who must be designated as a standalone subcontractor and must be certified to provide HCBS waiver services.*

**State of Alabama Accounting and Resource System (STAARS)** - *As the State's new enterprise-wide accounting system, STAARS supports all financial, procurement, and human resource transactions. All vendor interaction including solicitations, purchase orders, payments, and receipts are maintained in STAARS.*

**Subcontractor** - *Any entity who contracts with a contractor for waiver claims billing only.*

**Support Coordinator (SC)** - *Formerly known as case manager; assists waiver recipient to access necessary services and benefits.*

**Targeted Case Management (TCM)** - *Case management services aimed specifically at special groups of participants, which helps beneficiaries to gain access to needed medical, social, educational and other services.*

**Temporary Operating Authority (TOA) -** *Once a provider's application is approved for a new setting or new service, the program is issued a letter of Temporary Authority by the ADMH/DDD Commissioner allowing it to operate for a period of up to 6 months.*

**Tenant** - *The individual who has chosen the residential home and is in agreement with the terms set forth by the provider in the lease/rent or residency agreement.*

**Tuberculosis (TB)** - *A potentially serious infectious disease that mainly affects the lungs, cause by bacteria (Mycobacterium tuberculosis).*

**Values (Certification Tool)** - *The main topic in the Certification Tool that contains necessary Requirements and Elements for all DDD provider organizations. The term Values has replaced the use of the term "Factors" from the previous ADMH-DDD Certification Tool.*

**Vocational Rehabilitation Services** - *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 participant receiving this service that: A generalized service that helps a participant progress down a defined pathway to employment. Only participants interested in integrated and competitive integrated employment should be referred to VR.*

**Waiting List (WL)** - *The list of individuals who have submitted eligibility documents to be considered as a waiver recipient for the ADMH-DDD HCBS waivers*


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