ALABAMA DEPARTMENT OF MENTAL HEALTH

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

APPLICATION AND SUPPORTING DOCUMENTATION

FOR CERTIFICATION AS A

SPECIALIZED MEDICAL RESIDENTIAL SERVICES PROVIDER

DO NOT COMPLETE IF ALL WAIVER REQUIREMENTS ARE NOT IN PLACE

REQUIREMENTS

1. **24/7 LPN services.** LPN serves as one of at least two staff on duty in a home with no more than 4 persons residing. LPN provides ongoing treatment and medical services and supports as identified by assessed needs of an RN, other Medical Professionals, and the person centered team.
2. **RN services.** The RN serves in an administrative capacity such as a Home Manager or QDDP. The RN provides clinical supervision to the LPN and oversees training, implementation and compliance with the Department of Mental Health's Nurse Delegation Program. Other duties may include serving as back-up staff in the absence of the LPN, procurement of needed specialized medical supplies and equipment, primary liaison between individuals receiving services and all required health care professionals, and annual nursing assessment, etc.
3. **Physician services.** The agency ensures that individuals have a primary care physician or group of physicians. **The individual, their family, and/or their legal representative, to the extent possible, choose their primary care physician or group.** The agency provides a comprehensive set of medical records to the primary care physician or group to include summary of current diagnoses, treatment modalities and their rationale, history of previous conditions and issues associated with current diagnoses and successful and failed treatments, etc.
4. **Staff training.** The agency ensures that all staff working with individuals supported are provided with specific training related to all aspects of person's medical situations, signs and symptoms related to specific conditions, and other specialized delegated treatments as outlined in the Nurse Delegation Program and Nurse Practice Act.
5. **Medical needs.** To qualify for a special medical services provider rate, individuals must have 3 or more medical conditions listed on the attached page. Individuals must be screened using the Health Risk Screening Tool (HSRT) and have the results addressed at the individual's person-centered planning meeting.

I hereby certify that I am willing and capable and have all necessary resources to provide supports and services as outlined above to the described target population.

_____ _____

Executive Director Date

Note: Attach staffing pattern, RN and LPN Credentials, and Program Description

SUPPORTING DOCUMENTAION

SPECIALIZED MEDICAL RESIDENTIAL SERVICES

MEDICAL CONDITIONS

1. Type I or II Diabetes requiring insulin
2. Dementia
3. Intractable Epilepsy
4. Recurrent Skin Breakdown
5. Serious Vascular Disorders
6. Oxygen Dependent
7. Tracheotomy Care
8. Peg Tube Feeding/Care
9. J Tube Feeding/Care
10. Colostomy Care
11. High Fall Risk with History of Injuries
12. Cancer/Treatment
13. Degenerative/Progressively Debilitating/Neurological Conditions
14. Leukopenia
15. Severe Cerebral Palsy, Spasticity, Kyphoscoliosis
16. High Choking Risk (dysphagia, special diets or feeding devices)
17. Other_____
18. Other_____

I hereby certify that the individuals currently receiving services and those that will be provided services in this location have or will have 3 or more of the above medical conditions.

_____ _____

Executive Director Date

Note: Attach staffing pattern, RN and LPN Credentials, and Program Description