Alabama Department
of Mental Health
connecting mind and wellness

Division of Developmental Disabilities (DDD)

Provider Operational Guideline Manual

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

Revised April 10, 2023

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

Letter from Associate Commissioner

May 31, 2021

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

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

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

Sincerely,

Terry L. Pezent
Associate Commissioner, ADMH-DDD

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Summary of Changes Table

The New and Revised Guidelines are listed below:

Operational Guideline #	Operational Guideline Title	Action Taken
	Process for Reviewing and Updating the Operational Guidelines	Revised
A.1.1	Intake/Information and Referral	Revised
A.1.2.a	Criteria for Determining Eligibility and Placement on the Waiting List	Revised
A.1.3	Inventory for Client and Agency Planning (ICAP) for Community Services	Revised
A.1.6.e	Request for Proposal Seeking Services for Individuals	Revised
A.2.1.b	Appeals Process for Adverse Actions	Revised
A.3.1	Person Centered Plan (PCP) Processing (formerly Plan of Care)	Revised
Exhibit	Freedom of Choice Form	Revised
Exhibit	Monitoring – Individual Experience Assessment Survey	Revised
A.5.10	Direct Service Provider Operational Requirements	Revised
Exhibit	Rights Assessment	Revised
A.5.11	HCBS: Provider Owned and Controlled Properties	New
Exhibit	Rent Residency Agreement Guidelines	New
A.6.3.b	Promotion and Protection of Individual Rights	Revised
A.6.3.h	Staff Resources and Supports	Revised
A.6.3.i	Positive Services and Supports	Revised
A.7.5	Comprehensive Support Systems (CSS) Teams	Revised
A.10.4	Money Management for Individuals Served	New
Exhibit	Provider Money Management Guidance	New
Section B	Community Waiver Program (CWP) Guidelines	New

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

Kathy Sawyer
Associate Commissioner, ADMH-DDD

April 10, 2023

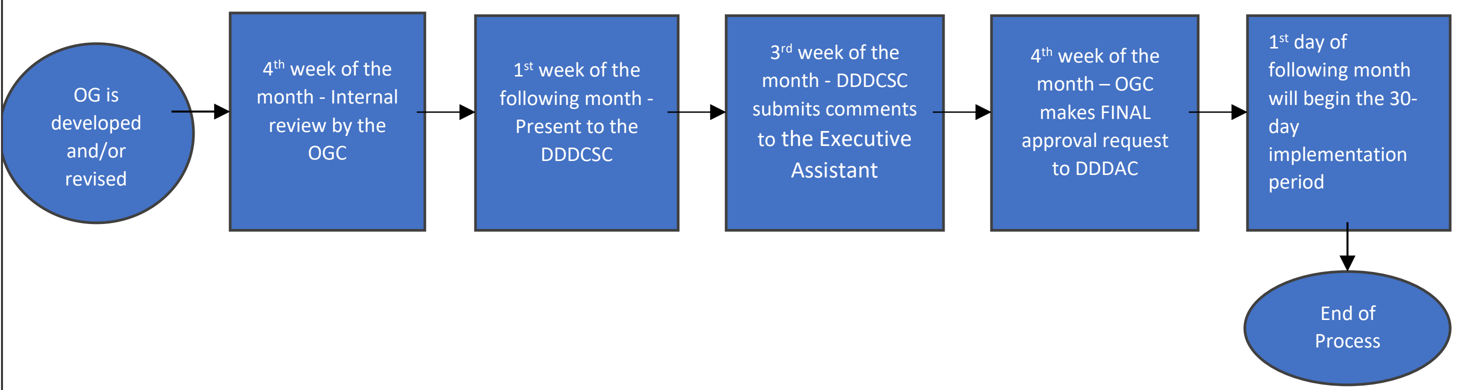
Review steps and timeline:

**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 aspecific 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.

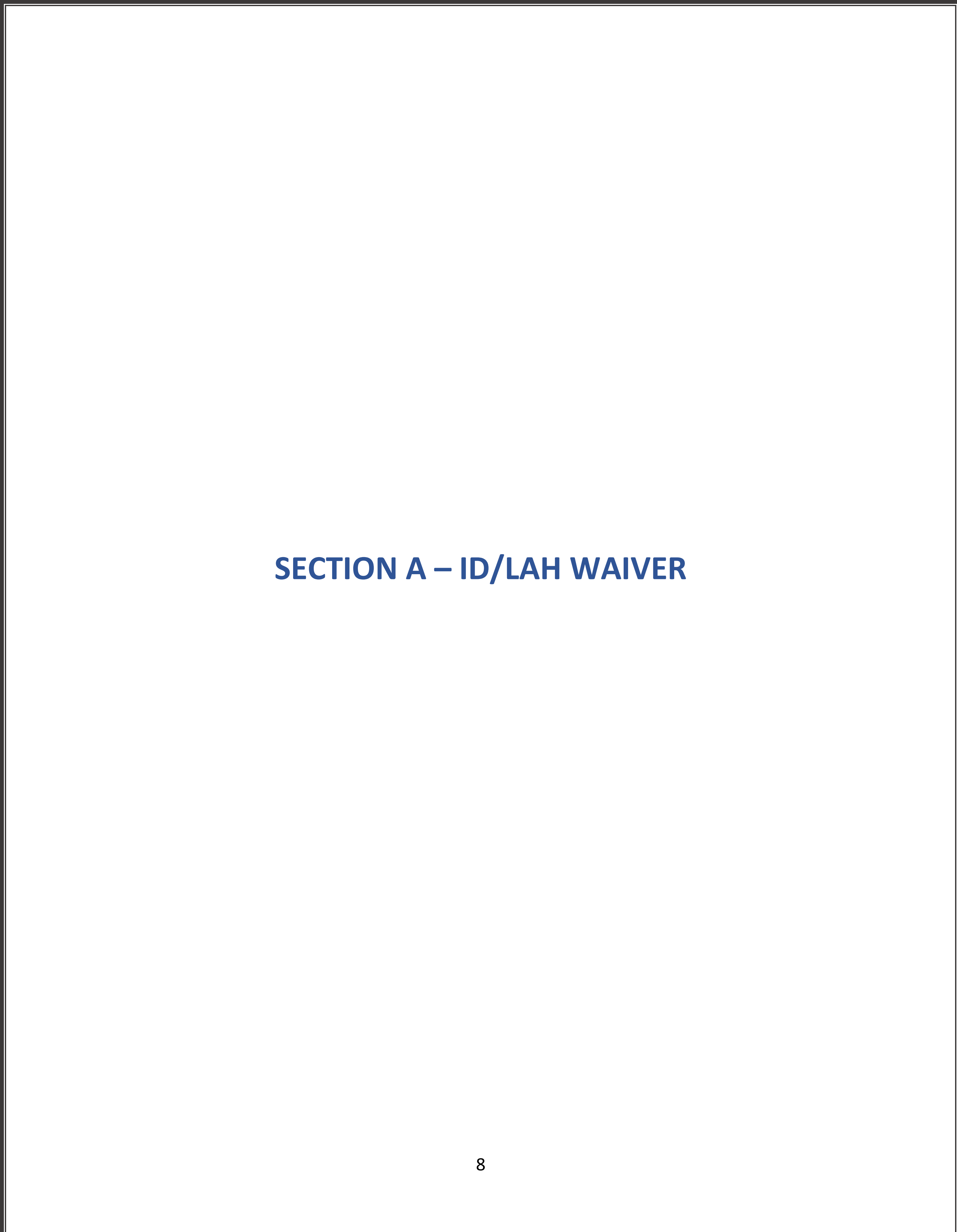
(8) Include an assurance that interventions and supports will cause no harm to the individual.

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

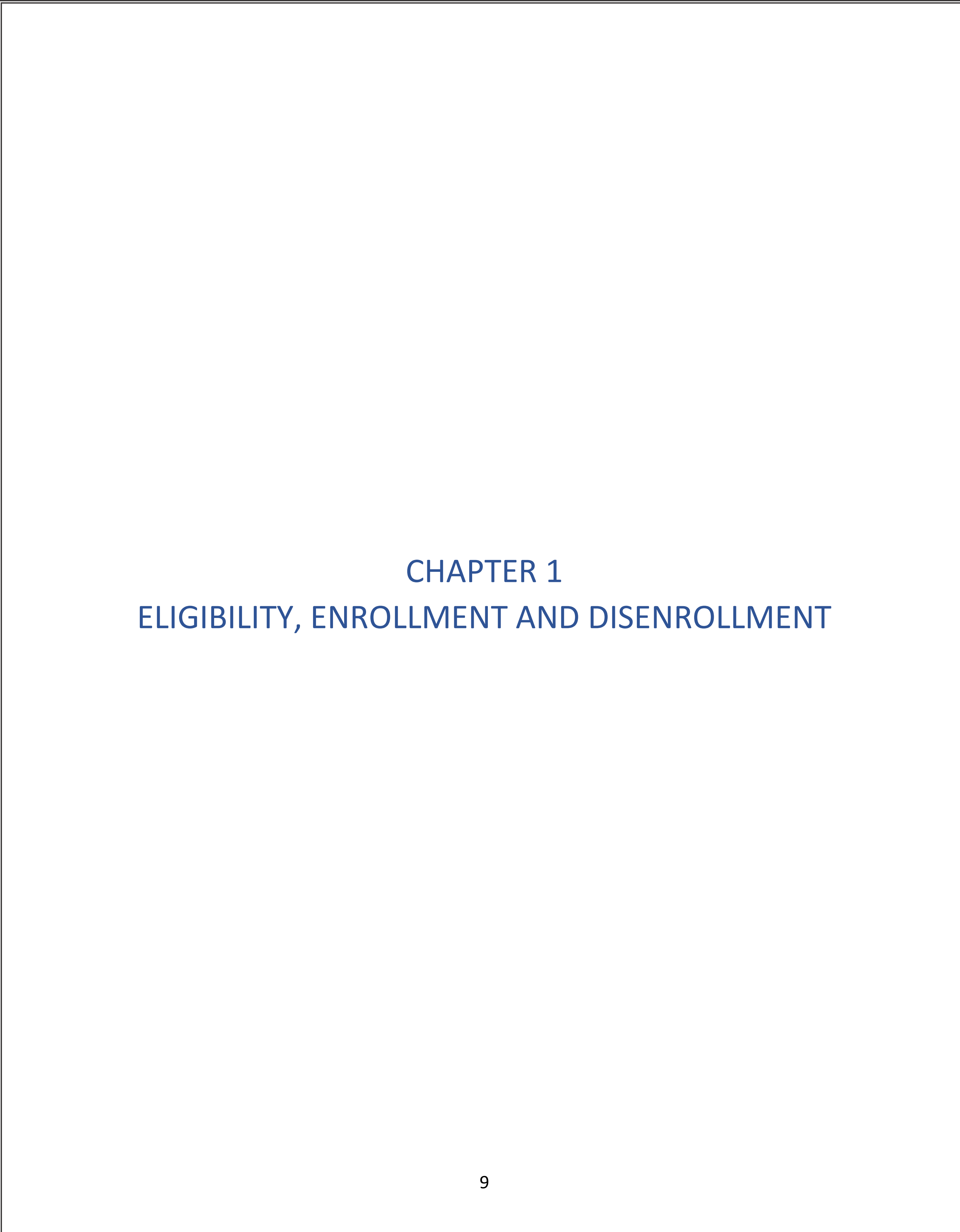
(i) A nursing facility;

(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.



SECTION A – ID/LAH WAIVER



CHAPTER 1
ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

A.1.1 Intake Information/Referral

Responsible Office: Eligibility, Enrollment and Disenrollment
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
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
Definitions: Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DD); Call Center (CC); Home and Community Based Services (HCBS), Support Coordination Agency (SCA)- formerly referred to as Case Management Agency, Support Coordinator (SC)- formerly referred to as case manager, Division of Developmental Disabilities Information Management System (DDD IMS)
Procedures: Those seeking services for person with intellectual disabilities through the Alabama Department of Mental Health Division of Developmental Disabilities should:

1. Contact the Division of Developmental Disabilities Call Center at 1-800-361-4491.
2. The Call Center staff will complete the initial contact application on referrals for individual's three (3) years of age and up who meet the eligibility requirements and will request the Intellectual Quotient (IQ) (69 and below) of the person in need of services in addition to other pertinent information.
3. CC staff will accept calls from the individual requesting services, the legal guardian, the primary caregiver, or other interested parties who have consent to relay information and who will be responsible with assisting with the referral process.
4. Within two business days, an initial contact form will be sent via a note in DDD IMS to the local designated support coordination agency or other designated point of entry.
5. CC staff will make referrals to the SCA based solely on verbal report of the caller. CC staff will not deny 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. The Initial Contact Information Form will be sent to the SCA via the DDD IMS notes. This form will have the type of referral checked in the box at the top. There are three options; the first is the Initial Application Referral which reflects a first-time applicant requesting services. The second is Referral for Update which means there has been a call received from/for someone who already has been referred to the SCA but a Notice of Incomplete Application was sent to the requester. Third is the Info/Referral only which is used for persons looking for services outside of ADMH-DD. The same information sent to SCA is sent to the ADMH-DD Regional office Waiting List Coordinator. The eligibility determination process continues to be the prerequisite for all categories.

11. CC staff will send a letter to the person calling, verifying the date of call and that their requests have been forwarded to the designated SCA in their area to continue the application process.

12. CC staff will open a DDD IMS enrollment for the person in need of service. It is the responsibility of the SCA to make a change in DDD IMS reflective of the assigned support coordinator from the CC.

13. CC staff will send the application for services on referrals made by Department of Human Resources (DHR) on children or adults in their custody to the DHR, ADMH-DD contact, to the support coordination agency, to the Regional Community Services Director and the Community Services Waiting List Coordinator.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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:** 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.

***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.

*Note: Initial Contact Information Form

A.1.2 Waiting List

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

Responsible Office: Support Coordinator Services

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

Effective: October 1, 2021

Revised: February 6, 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: ID, LAH, CWP

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

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 and the 310 Board Agency of the new application via the DDD IMS;
    c. Determines the county of residence of the caller and notifies them of the specific Waiver programs offered in that county,
        i. The ID and LAH 1915c Waivers are available in counties not covered by the Community Waiver Program.
        ii. In counties covered by the Community Waiver Program, the Community Waiver 1915c and the Community Waiver 1115 HCBS Programs 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 A.1.4) and the ICAP (reference ADMH-DDD OG A.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.
      i. For an applicant eighteen years of age or older, two evaluations are required: one evaluation must be dated on or after the eighteenth birthday; and one evaluation must be dated prior to eighteenth birthday.
      ii. For a child applicant, this evaluation must be dated within three years of the date of application.
   b. An ICAP Compuscore report completed within ninety days of the date of a complete application packet.
   c. 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:
      i. 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.
      ii. The Diagnosis Record in ADIDIS (for Learning area)
   b. An ICAP Service Score of 85 or lower, as computed by the ICAP Compuscore.
   c. The applicant achieved a full-scale IQ score below 70, evidencing the presence of an intellectual disability, documented before the age of eighteen.
      i. For children, the IQ evaluation must be within three years prior to date of waiver application.
      ii. 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.
      iii. 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.d. may apply.
   d. 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.
6. 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 Waiting List for services if they scored below 480 in at least one of the following ICAP domains: Social & Communication, Personal Living, Community Living, or Broad Independence.
7. 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.

8. In the event the needed additional information is not submitted within 60 days of the Waiting List Coordinator's DDD IMS notification, the application packet will be deemed incomplete, and the Waiting List Coordinator will send to the applicant a Notice of Incomplete Application (found in the Enrollments record in the DDD IMS). A copy of this notification will be recorded in the DDD IMS.
9. In the event the needed additional information is submitted within 60 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.
10. 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.
11. 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.
12. 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.

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

Responsible Office: Office of Community Programs, Call Center
Reference: ADMH Administrative Code 580-5-30-.13, Alabama Medicaid Code, Call Center Procedures
Effective: May 28, 2021
Statement: The Alabama Medicaid Agency designates the DMH as the entity authorized to determine individuals' eligibility for participation in the Medicaid Home and Community-Based Services (HCBS) Waiver for individuals with Intellectual Disabilities (ID Waiver) and for the Alabama Living at Home Waiver (LAH Waiver). Within the DMH, the oversight and monitoring of day-to-day operations of the Waiver programs are conducted by the Division of Developmental Disabilities through its Central Office and its Regional Community Service Offices.
Purpose/Intent: To centralize the process of wait list eligibility for ADMH inpatient applicants utilizing the DD Call Center and Regional Community Services Offices as main points of contact to improve efficiency and uniformity in eligibility determinations, statewide.
HCBS Waivers: ID, LAH
Definitions: ADMH Inpatient Facilities- Bryce Hospital, Mary Stark Harper Center, Taylor Hardin Secure Medical
Facility (THSMF) DDD IMS – Division of Developmental Disabilities Information Management System. This system has previously been known as MRSIS.
Procedures:

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

A.1.2.c Waiting List – Entry to Services

Responsible Office: Regional Community Services
Reference: 1915c Home and Community Based Intellectual Disabilities Waivers; Wait List Selection Process, A.1.2.d; Administrative Code 580-5-30-.13
Effective: Historical Practice
Revised: April 1, 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, CWP
Definitions: RCS (Regional Community Services); Interchange (Medicaid Database); ICAP (Inventory for Client and Agency Planning); Request for Proposal (RFP); ID (Intellectual Disabilities); LAH (Living at Home)
Procedures:

1. DDD Central Office notifies RCS of the applicants on the Waiting List identified for entry to Waiver services.
2. The Waiting List Coordinator:
   a. Identifies those applicants specific to their Region approved for Waiver services.
   b. Sets the Waiting List status of each approved applicant to "Pending" in the web-based application.
   c. Verifies the Medicaid eligibility for Waiver placement of each approved applicant via the Interchange.
   d. Reviews the Waiver eligibility information submitted at the time of application and, if necessary, requests updated information (including an ICAP score along with the ICAP booklet within 60 days, IQ assessment if applicable) to verify current eligibility, from the responsible Support Coordination Agency(s) via the web-based application (See OG A.1.2.a Criteria for Determining Eligibility and Placement on the Waiting List)
      i. The Support Coordination agency responds to the request within 5 business days with an explanation and timeline of actions to be taken and targeted date of completion via the web-based application, making the WL Coordinator a note recipient.
      ii. The WL Coordinator reviews the record within 3 business days of the response from the Support Coordination agency and at minimum every 10 business days until resolution.
      iii. The Support Coordination agency will note any issues that arise preventing the submission of the documentation. After 60 days, the application will be considered incomplete and the Waiting List Coordinator will send the applicant a Notice of Incomplete Application. A copy of this notification will be recorded in the DDD IMS.
      iv. 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).

v. 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

e. If all eligibility information is available the WL Coordinator notifies the responsible Support Coordination agency(s), via the web-based application, of each applicant approved for Waiver services, provides the verified Medicaid eligibility information for each, and directs them to serve the identified person(s).

f. Adds to the Placement Committee agenda each applicant approved for the Waiver and:

   i. Reviews documentation in the web-based application and communicates with the Support Coordinator at least biweekly to track and report progress toward entry to Waiver services.

   ii. Collaborates with the Support Coordinator to troubleshoot and resolve any barriers to entry to Waiver services (e.g., inaccurate contact information, non-response to RFP(s)).

   iii. In the event of non-response to RFP's, forwards to other applicable Regional Offices (CSD or designee) the RFP(s) prepared by the Support Coordinator for each applicant identified for entry to Waiver services, allowing 7 business days for providers to respond.

3. The Support Coordinator:

   a. Contacts the approved applicant or the caregiver, identifies needed Waiver services, and prepares the RFP, as noted in f- iii, above.

      i. 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

      ii. 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).

      iii. 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.

      iv. The WL Coordinator will follow the instructions provided in the Assistant Commissioner's Internal Executive Order dated June 8,2022.

   b. For each applicant, circulates the RFP for each service identified in the PCP to all providers within the applicant's catchment area, allowing providers seven (7) days to respond.

   c. Uploads the RFP(s) in the web-based application and include the date of submission to providers.

   d. Provides weekly updates to the Waiting List Coordinator on response(s) or non-response to the RFP(s)

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

Responsible Office: System Management
Reference: ADMH Administrative Code 580-5-30-.14, 1.2.a Criteria for Determining Eligibility and Placement on the Waiting List, A.1.2.c Waiting List – Entry to Services
Effective: Historical Practice
Revised: April 7, 2023
Statement: A list of names will be selected periodically from the Statewide Wait List
Purpose/Intent: To ensure eligible individuals waiting for services are admitted periodically at time frames determined by the ADMH Central Office
HCBS Waivers: ID, LAH, CWP
Definitions: Central Office (CO); Mental Health (MH); Regional Office (RO)
Procedures: Upon notification to the CO MH Specialist II responsible for the submissions of applications to the Alabama Medicaid Agency (AMA), the CO MH Specialist II will select the number of individuals for the wait list as instructed by the CO Director of System Management and/or CWP Director by:

1. Running the report through the following process:
    a. At the System Home Screen choose the **ID Wait List**
    b. At ***Filters*** select work queue that is equal to "**Approved**"
    c. Select ***Tie-breaker date*** as the number instructed by the Director of System Management and/or CWP Director
    d. Select ***Status*** equal to "**Waiting, no services being provided**"
    e. Click ***Search*** and the report will be extracted
    f. Click on "**Alabama ID wait list ranking**" in blue print at the top of the page
    g. Export the data in desired program format
2. Save and Print the report.
3. Add information for persons pulled into the report to the Central Office Total Waiver Count spreadsheet.
4. The MH Specialist II will forward the list to the Director of System Management and/or the CSD.
5. The list will be sorted in ranking order showing those with the most critical need in the higher numbers as follows: **1**) 81-71, **2**) 70-61, **3**) 60-51,**4**)50-41, **5**)40-31, **6**) 30-21, **7**) 20-11, and **8**) 10-1.
6. The Director of System Management/CSD will use the following methodology to derive the total number of slots available at each RO by dividing the number of slots selected by the number of RO. (Example: 200 slots are selected and divided by the number of RO (5) totaling 40)
7. The MH Specialist II will send the wait list to all the RO Community Services Directors who will notify the RO Wait List Coordinator.
8. The CSD in each office will take the sum (40) and divide it by the number of ranks mentioned above (40/8=5) to select from each rank mentioned above to obtain the number of applicants from each rank 1-8 to pull equally.
9. If there are variances in the rank 1-8 based on applicant response, non-response or number waiting in each rank, the next person on the list in that ranking is chosen (Example: Region 1 has 2 persons selected from the list one in ranking 2 (70-61) and the other in 5 (40-31) who died before a slot became available. These two slots will be reallocated to the same rank 2

and 5 respectively until all ranking allocations are filled).

10. In the event that a rank has less than the number allocated, the slot should be moved to rank number 1.
11. The RO Wait List Coordinator verifies each individual's eligibility, as evidenced by a "Yes" answer to the applicable eligibility question (1915c waiver or 1115 Demonstration) within the Alabama Wait List Application Report in the individual's DD Information Management System record and verifies each individual's Medicaid eligibility status. [Re: ID/LAH Waiver OG A.1.2.a]
12. The RO Wait List Coordinator enters a note in the DD Information Management System that alerts the Support Coordinator as to action(s), if any, needed to begin the initial application process. [Re: ID/LAH Waiver OG A.1.2.c]
13. The RO Wait List Coordinator will notify the appropriate Support Coordination Agency and/or CWP Support Coordination Supervisor to begin the initial application process for those individuals identified for initial admission to the waiver within 60 business days.
14. The RO Wait List Coordinator will put the individual's case in "**pending**" status, in the DD Information Management System, to ensure the individual's name is not duplicated on the next wait list selection.
15. The CO MH Specialist II will monitor the initial applications and add the waiver enrollment dates for individuals processed, indicating the application was processed through the Alabama Medicaid Agency's Long-Term Care software.
16. The CO MH Specialist II will contact the RO Wait List Coordinator within 7 business day to determine the status of those applications not processed.
17. The CO MH Specialist II will report to the CO Director of Systems Management and/or CWP Director the number of individuals selected for each period and updates on the number of individuals whose applications have not been processed.
18. After all steps of the process have been followed, if the applicant has not been contacted, the Wait List Coordinator should follow the process outlined below as stated in the Associate Commissioner's Internal Executive Order dated June 8, 2022.
    a. Effective June 15, 2022, upon 60-day notification a waiver application is incomplete due to inability to make contact, the ADMH DDD Wait List Coordinator (WLC) will, as the FIRST ATTEMPT TO CONTACT, send notification of the individual's selection to enroll in an ADMH HCBS Medicaid Waiver by certified mail to the individual's last known address (AMA MSIQ address) and/or notify individual by personal visit to the individual's address of record.
    b. If contact is unsuccessful and/or no response within 30-days of attempted contact, as the SECOND ATTEMPT TO CONTACT, the ADMH DDD WLC will again attempt to contact the individual selected for waiver enrollment by certified mail to the individual's last known address (AMA MSIQ address) and/or by personal visit to the individual's address of record, informing them of their selection from the ADMH HCBS Waiver Wait List for enrollment into an ADMH HCBS Medicaid Waiver.
    c. If not successful and/or no response within 30-days of second attempt to contact, the WLC will notify the ADMH-DDD Associate Commissioner, who will complete the Waiver Enrollment - Waiting List 'Failure to Contact' letter notifying Alabama Disabilities Advocacy Program of the failed attempts by certified mail and/or personal visit to ADAP of the failed attempts and requesting assistance to contact

the selected individual.

If ADAP is unsuccessful to contact and/or fails to notify ADMH DDD of their efforts within 45- days of receipt of notification, the individual will be 'skipped over for enrollment' and maintained on Waiting List to be identified as 'inactive'.

A.1.2.e Interregional Medicaid Waiver Transfers

Responsible Office: Regional Community Services
Reference: Request for Interregional Medicaid Waiver Transfer Form
Effective Date: Historical Practice
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
Definitions: 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 CSD 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 CSD notifies the receiving CSD of the request for transfer/services.
5. The receiving CSD determines if the needed/requested services are available in the receiving Region and informs the sending CSD of the results of that determination.
6. The sending CSD 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:
        i. 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.
        ii. Conducts a discharge meeting.
        iii. 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 CSD notifies the receiving support coordination agency to:

i. Coordinate with the sending support coordination agency to exchange all necessary documentation (e.g., releases of information, assessments, Plans of Care, etc.).
ii. Establish timeframes for choice visits and a projected date of transfer.
iii. Sign and return the Interregional Medicaid Waiver Transfer Form, including the date receiving providers were notified of the transfer.

8. The receiving CSD forwards a copy of the Interregional Medicaid Waiver Transfer Form to the sending CSD 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 (ICAP) for Community Services

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

1. Prior to administering the ICAP, the Support Coordinator will be trained 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
        i. 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:
        i. Client information
        ii. Section A. Descriptive Information
        iii. Section B. Diagnostic Status
        iv. Section C. Functional Limitations and Needed Assistance

v. 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.

A.1.4 Criticality Assessment

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30
Effective: Historical Practice
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
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); CSD (Community Services Director)
Procedures:

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

A.1.5 Request for Psychological Testing

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30-.14 Eligibility and Level of Care Determinations for Medicaid Waiver Programs
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
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); RFA (Request for Action); ICAP (Inventory for Client and Agency Planning); CSD (Community Services Director); IEP (Individualized Educational Plan); CSS (Comprehensive Support Services); BPE (Behavioral & Psychological Evaluator)
Procedures:

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

b. The assigned tester will contact the support coordination agency to schedule a testing date, secure an area for testing with the support coordination agency, and gain any additional information regarding the individual who will be tested.
c. The assigned tester will enter test results in DDD IMS and upload psychological report within 10 business days of the test administration. The original psychological report will be filed in the office of the BPE in Regional Community Services.

A.1.6 Waiver Services

A.1.6.a Wait List for Services to Children

Responsible Office: Regional Office
Reference: ADMH Administrative Code 580-5-30; Pursuant to the current DMH/DD policy of the DD Call Center, referrals are accepted on individuals ages 3 and above.
Effective: Historical Practice
Statement: Referrals of children ages 3 – 21 to DMH/ID/DD are for alternative residential services and / or specialized educational services. A significant number of these referrals are received from the Department of Human Resources (DHR) and the Alabama State Department of Education (ALSDE).
Purpose/Intent: To ensure that adequate and appropriate documentation is secured on all referral of individuals ages 3 – 21, to include any age-appropriate psychological assessments, current IEP (including eligibility sheet), medical records, etc. To ensure that all services rendered to children are age appropriate and provided in the least restrictive setting.
HCBS Waivers: ID, LAH
Definitions: EPSDT – Early and Periodic Screening, Diagnostic and Treatment Services: Medicaid program benefit providing a comprehensive array of prevention, diagnostic and treatment service for low-income infants, children, and adolescents under age 21 as specified in Section 1905(r) of the Social Security Act.
MNC - Multiple Needs Child – a child coming to the attention of the juvenile court who is at imminent risk of out of home placement or placement in a more restrictive environment and whose needs require the services of two or more of the following entities: Department of Youth Services, Department of Human Resources, Department of Education, Department of Mental Health, and the Juvenile Probation Office. IEP – Individualized Educational Plan, FAPE – Free and Appropriate Public Education, LEA – Local Education Agency
Procedures:

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

7. If the LEA has indicated that FAPE can be provided, but an alternative residential setting is being requested, an RFP will be distributed to applicable DMH providers by the appropriate Regional Community Services office.

A.1.6.b Waiver to Waiver Transfers

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

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

A.1.6.c Termination of Waiver

Responsible Office: 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:

1. Hospitalization-termination one full calendar month of hospitalization.
2. Nursing Home placement-termination after 48 hours of placement
3. Moved out of state-termination after 60 days out of state
4. Death-immediately following notification.
5. No longer meets eligibility requirements-immediate
6. No longer request waiver services-immediate
7. Refusal to adhere to program requirements- 30 days following written notification
8. Transfers to another waiver program-on the last working day of a month.
9. Unable to locate waiver participant-30 days after written notification to last known address remains without response.
10. Financially ineligible-immediate after notification from the Medicaid District Office.

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

A.1.6.d Waiver Admission & Discharge

Responsible Office: System Management

Reference: 1915c Home and Community Based Intellectual Disabilities Waiver

Effective: Historical Practice

Revised: May 28, 2021

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

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

HCBS Waivers: ID, LAH

Definitions: LTC-2 (Notice of HP Enrollment or Termination Action), RO (Regional Office), CO (Central Office)

Procedures:

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

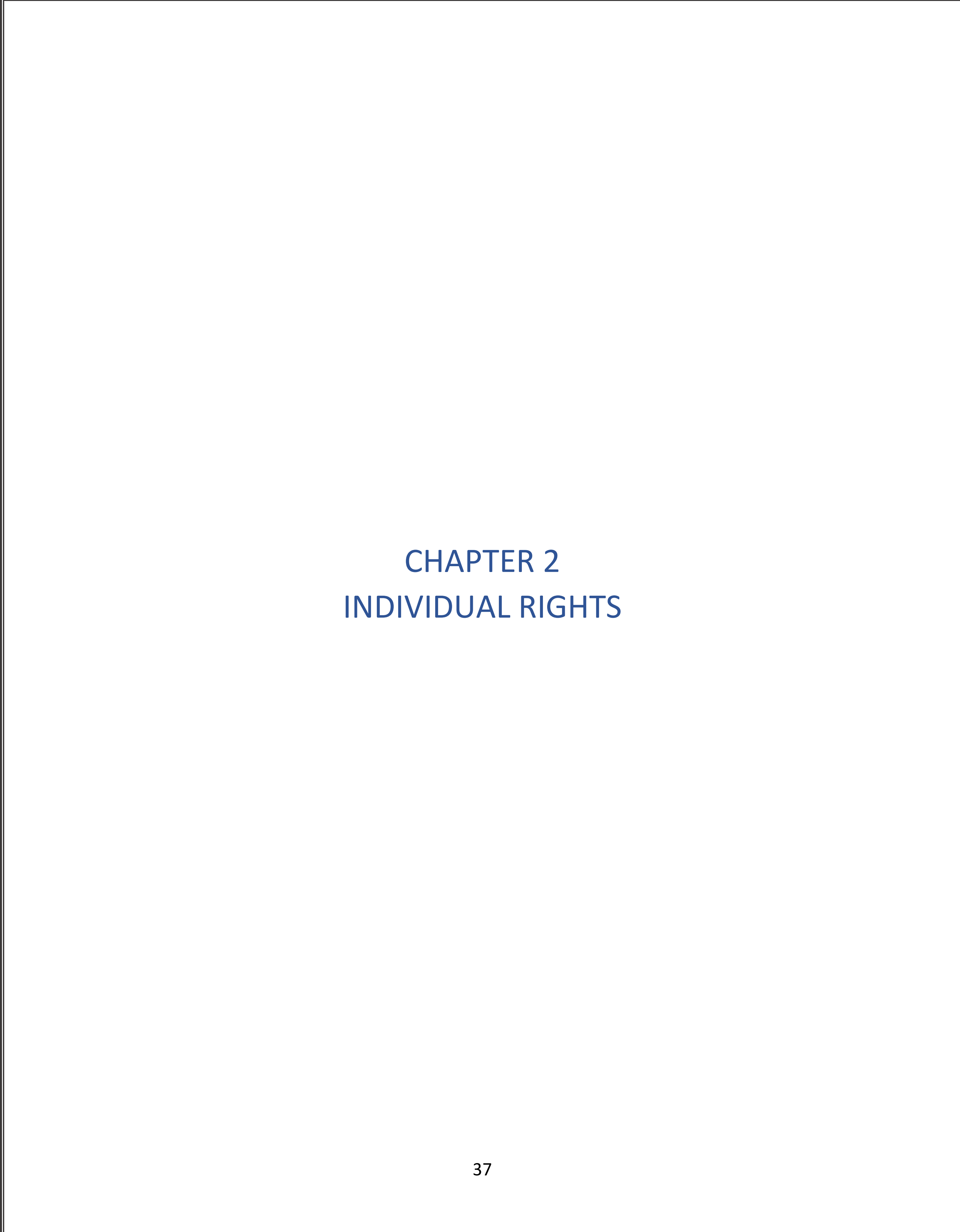
A.1.6.e Request for Proposal Seeking Services for Individuals

Responsible Office: Regional Community Services
Reference: 1915c Home and Community Based Intellectual Disabilities Waiver
Effective: Historical Practice
Revised: April 7, 2023
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
Definitions: 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.

*Note: ADMH Request for Placement Form and ADMH Request for Placement – Instructions *(See List of Forms Table)*



CHAPTER 2
INDIVIDUAL RIGHTS

A.2.1 Appeals

A.2.1.a Waiver/Wait List Eligibility Appeals

Responsible Office: Office of Community Programs, Support Coordination, currently Office of PBS
Reference: Alabama Administrative Code, Alabama Medicaid Administrative Code
Effective: Historical Practice
Statement: The Alabama Department of Mental Health (ADMH) is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community- based services (HCBS) in accordance with the provisions of the Home and Community-Based Waiver for Persons with Intellectual Disabilities.
Purpose/Intent: The process of appeals is one in which cases are reviewed, where HCBS waiver applicants and related parties request a formal change to an official decision. Appeals function both as a process for error correction as well as a process of clarifying and interpreting the criteria and standards by which the original decision was rendered.
HCBS Waivers: ID, LAH, CWP
Definitions: Appeal- a formal request that a decision, as in a legal or official one, be changed.
Procedures:

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

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

Responsible Office: Individual Rights

Reference: 42-CFR 431.210 (Subpart E); ID and LAH Waivers and Community Waiver Program (CWP)

Effective: December 30, 2021

Revised: July 28, 2022

Statement: ADMH/DD Division provides an opportunity to request an appeal through an Informal Conference and/or a Medicaid Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are denied service(s), choice of provider(s), or whose services are(b) suspended, reduced, terminated, or delayed. ADMH/DD Division provides Notice of Appeal Rights Adverse Action as required in 42 CFR §431 .210.

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

HCBS Waivers: ID, LAH, CWP

Definitions: Informal Conference – the informal conference is an opportunity for the individual and/or representative to have the adverse action reviewed by the ADMH-DDD for decision and resolution; RFA (Request for Action – the form used to describe request (e.g., service, purchase, provider), CSD (Community Services Director)

Procedures:

The DD Division will adhere to the following procedures for appropriate notification of adverse action taken by the regional office, the steps to appeal through Informal Conference and the process for decision making and resolution:

1. Written advanced notification to the individual or responsible person must include:
    a. Date of Notice
    b. The specific adverse action being taken
    c. Specific information about the reason(s) for the adverse action
    d. The effective date of the action
    e. The individual's right to request an informal conference at ADMH-DDD and/or a fair hearing with Alabama Medicaid and the procedures for doing so following established procedures
    f. An ADMH-DDD informal conference is <u>not</u> an alternative to a Medicaid fair hearing.
    g. Services involved will continue at the current level according to the Person-Centered Plan (PCP) until the appeal process has been exhausted. Services requested, denied and/or not currently on the PCP will not be provided during the appeal process
    h. Point of contact if there are questions regarding the action
    i. **<u>NOTE</u>**: If denial relates to (b) services that are denied, suspended, reduced, or terminated, DMH must issue a written notice at least 10 days prior to the action to the individual, and/or representative indicating their right to appeal.
2. To appeal, the individual must send a written request along with the Notice of Appeals Rights Adverse Action form no later than 15 calendar days after the effective date printed on the Notice to the Division's Office of Appeals and Constituent Affairs at the ADMH street address indicated on the Notice of Appeal Rights Adverse Action form. The Appeals Coordinator will choose a panel of three members to review the denied RFA.
3. Review Panel:
    a. The review panel 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.

   b. The panel will review the denied RFA and other information individually making note of any questions that may arise and complete the Initial Review of Denial Form.
4. Teleconference:
   a. A teleconference, if needed, will be scheduled with the 1) individual and as appropriate, the individual's representative (ex., family, guardian, authorized representative), 2) panel participants, 3) Staff (CSD or CWP Director) responsible for denying the RFA, 4) Individual's Support coordinator AMA Waiver Program Manager.
   b. The teleconference will provide the individual and their representative the opportunity to offer supporting information as part of the review. The panel will also utilize the time to ask any specific questions to the staff, individual and/or their representative, or the panel that may be needed to provide more clarity.
5. Decision Making and Notification:
   a. Following the teleconference, the panel will complete the Review of Denial Form indicating reasons for their decision
   b. The panel will then meet to reach agreement on the final informal conference decision to either reverse or uphold the original decision
   c. The panel will select a panel participant who will 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:
      i. Description of initial request that warranted a denial
      ii. Action(s) taken to review the appeal
      iii. Final informal conference decision (denial upheld or reversed) and supporting reason (resource or other information to support decision)
      iv. Effective date of decision (if appropriate)
      v. 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.
   f. The Appeals Coordinator will then 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, CSD, the ID/LAH/CWP Waiver Director, the Regional Office Fiscal Manager, and others as appropriate.

Note: Notice of Appeal Rights Adverse Action Form

A.2.2 Dissatisfaction of Services (Repealed)

A.2.3 Informal Conference- Services

Responsible Office: System Management
Reference: 42CFR-431.200; ID Waiver; LAH Waiver; Medicaid Administrative Code
Effective: Historical Practice
Statement: Individuals receiving Waver Services will be provided appeal rights regarding decisions by the Operating Agency that adversely affects service provision.
Purpose/Intent: To ensure rights of waiver participants
HCBS Waivers: ID, LAH
Definitions: Adverse action means any decision that negatively impacts the waiver participant. This includes denials, reductions, delays in, or termination of any waiver service.
Procedures:

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

original decision made by the CSD through completion and submission of the Review of Denial Form.

h. The Associate Commissioner will notify the participant/family/guardian in writing of the decision in writing of the decision within 15 working days of the informal conference.
i. Due process appeal procedures to request a Medicaid Fair Hearing will be included with the response from the Associate Commissioner in the event the participant/family/guardian remains in disagreement.

A.2.4 Other

A.2.4.a Forensic Cases

Responsible Office: Office of PBS, Forensic Outpatient program
Reference: ADMH Administrative Code, Alabama Psychological Association, ADMH Legal standard
Effective: Historical Practice
Statement: In the case of Atkins v. Virginia (2002), the United States Supreme Court effectively prohibited the execution of individuals with intellectual disabilities by deciding that doing so violated the Eighth Amendment ban on cruel and unusual punishment. Individuals with intellectual disabilities frequently know the difference between right and wrong but, by definition, they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand others' reactions. Their deficiencies do not warrant an exemption from criminal sanctions but diminish their personal culpability.
Purpose/Intent: The Alabama Department of Mental Health may be so ordered by the circuit court of Alabama to facilitate the process for and conduct an Atkins Evaluation for an individual. A certified forensic examiner (as defined and credentialed by ADMH) and/or licensed expert in the field of intellectual and developmental disabilities must complete this evaluation.
HCBS Waivers: ID/LAH
Definitions: Atkins- In 2002, the United States Supreme Court held in Atkins v. Virginia that the execution of individuals with intellectual disabilities is unconstitutional because it violates the Eighth Amendment's prohibition against cruel and unusual punishments. The evaluation examines a person's culpability with regard to their intellectual ability and disabilities.
Procedures:

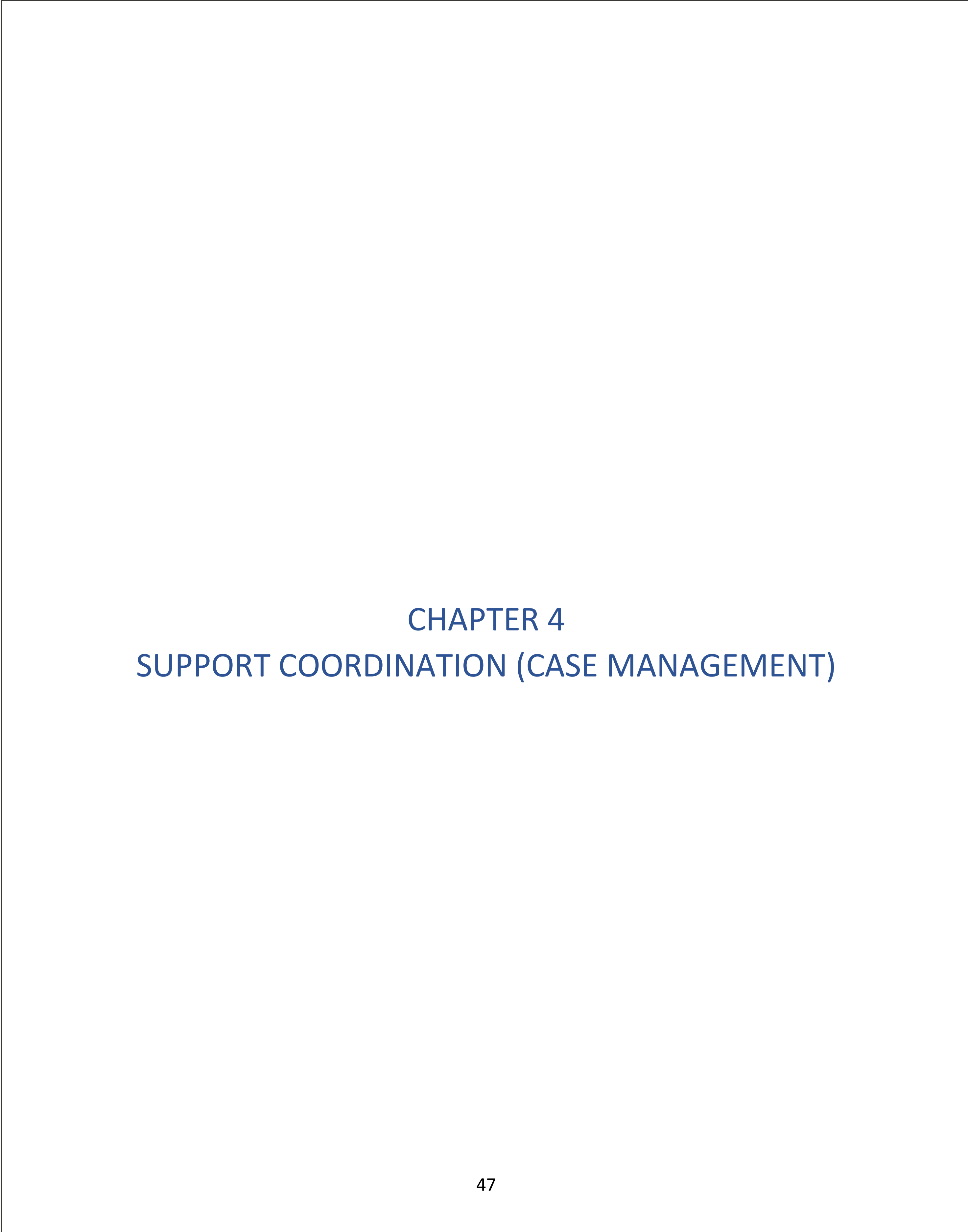
1. A court order for an Atkins (forensic) evaluation is received and processed first by ADMH legal department.
2. The Forensic Outpatient program coordinator receives the order from legal and facilitates assignments to a DMH contract forensic examiner in the community to complete evaluation.
3. In some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

CHAPTER 3
INDIVIDUAL SUPPORT PLANNING AND IMPLEMENTATION

A.3.1 Person Centered Plan (PCP) Processing Through DDD Information Management System (formerly Plan of Care)

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30-.13; 1915 Home and Community Based Intellectual Disabilities Waiver
Effective: Historical Practice
Revised: April 1, 2023
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
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); RFA (Request for Action); CSD (Community Services Director); POC (Plan of Care); RCS (Regional Community Services)
Procedures:

1. The 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.
4. The Waiver Coordinator:
    a. Reviews the PCP to verify that it is completed correctly, noting any needed changes to the Support Coordinator via DDD IMS Notes.
    b. Selects the Note as "Complete" upon verification of PCP accuracy, then tags the Fiscal Officer and Support Coordinator as Note Recipients.
5. The Fiscal Officer authorizes services in DDD IMS as indicated on the PCP.



CHAPTER 4
SUPPORT COORDINATION (CASE MANAGEMENT)

A.4.1 Funding for Support Coordination Agencies

Responsible Office: Administrative and Fiscal Operations
Reference: N/A
Effective: Historical Practice
Statement: Setting amounts for funding support coordination in the Department of Mental Health DD
Division Purpose/Intent: To establish a methodology to determine the amount of budget for support coordination to be provided to contracting agencies during the fiscal year.
HCBS Waivers: ID/LAH
Definitions: Support Coordination agencies were formerly referred to as Case Management agencies
Procedures: Each year when preparing the operations plan for the upcoming fiscal year regional fiscal managers will run the Units of Service Summary report or equivalent through the Department's web-based billing system. Days specified in the report will be 9/1 of the prior calendar year through 5/31 of the current calendar year. This report will identify the number of distinct individuals served by each program in that time period. Fiscal managers will use that number to calculate the number of dollars to contract with the agency by multiplying the number of distinct individuals identified by the number of currently allocated hours and the current support coordination dollar rate.

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

A.4.2 Request for Action/Services

Responsible Office: System Management
Reference: ADMH/DD Operational Procedures
Effective: Historical Practice
Revised: June 28, 2021

Statement: 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 account (see chart below) for changes to a Plan of Care for the following services. The Regional Office should make the determination within no more than **seven (7) working days** to expedite service delivery.

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 4pm the day before the meeting are considered for review. 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 ADIDIS.

Requests for Special Level Staffing (Behavioral and Medical), Positive Behavior Supports, and Comprehensive Support Services are submitted to the Regional Office Psychological and Behavioral Evaluator for review and approval.

Purpose/Intent: To expedite the RFA process
HCBS Waivers:
Definitions: RFA (Request for Action) – All changes to an individual's plan of care; DDD IMS (Division of Developmental Disabilities Information Management System)
Procedures:
An RFA is Required for the following:

1. Assistive Technology
    a. Include medical documentation and prescription
    b. Quote for service
    c. Denial from other insurance (if applicable)
2. Environmental Accessibility Adaptations (EAA)
    a. Include medical documentation
    b. Three (3) quotes for service

3. Specialized Staffing (SS)*
    a. Please reference Operational Guideline A.7.3 for required documentation
    b. Submit to the Regional Office Psychological and Behavioral 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 OG A.7.3
6. Increases in the original units authorized for any service
7. Increases over 12 hours per day for personal care
    a. If the PCP is not available via ADIDIS, it must be submitted with the request
    b. Documentation of need for the increase
8. Any service not included on the Person-Centered Plan or on the Plan of Care
    a. Day Habilitation, Community Experience, Employment Support, etc.
    b. Occupational Therapy, Speech Therapy, Physical Therapy – Prescriptions required
9. All Self-Directed changes
10. Specialized Medical Supplies
    a. Include Prescription
    b. Include Freedom of Choice
    c. Denial from other insurance (i.e., Medicaid State Plan)

Procedures for Support Coordinator when an RFA is Required:

1. Hold a team meeting of appropriate individuals
    a. Provide signed team meeting minutes and sign-in
2. Check Medicaid State Plan Services (SPS) and other insurance to ensure an item is not covered (if applicable)
3. Obtain required supporting documentation as necessary (prescriptions, medical documentation, quote, ICAP, PCP, etc.)
4. Complete the RFA Form with a detailed description (formal or informal assessments) that supports the request
5. Add service to the 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 is **empty**
        i. Exception - for hospital/nursing home discharges, the start date will be written as

the date of discharge

h. Obtain signatures

6. The Support Coordinator Supervisor reviews and submits the RFA Form and plan of care to the designated Regional Office RFA Account electronically through ADIDIS once all required documentation is received and leave in pending status
7. When additional information is requested for any request, the Regional Office will add a note in ADIDIS and tag the assigned Support Coordinator. It is imperative that Support Coordinators review their notes to avoid delays in services
8. Following approval of the RFA, review the authorizations tab to ensure the requested service(s) are added and notify the provider of service
9. Support Coordinator will update the Plan of Care tab in ADIDIS with the start date of service(s) and complete the record
10. In emergency situations, please indicate the start date on the RFA and the plan of care

Procedures for Regional Office when an RFA is Required:

1. Services cannot be initiated without an approved RFA
2. Verify all information is included on the RFA. If not, return to support coordinator with a note in ADIDIS.
3. Verify the documentation supports the need for service
4. Write the start date and end date on the plan of care and initial
5. Approved
    a. Sign and date approved RFA
    b. Upload approved RFA and plan of care in ADIDIS
    c. Generate approval letter to the participant and mail approval to participant
    d. Copy to Fiscal Manager in the Regional Office via ADIDIS to authorize service
    e. Email provider(s) the approval letter
6. Denied
    a. Sign and date RFA
    b. Upload denied RFA and Notice of Appeal in ADIDIS
    c. Generate the denial letter to the participant
    d. Denial Letter and Notice of Appeal is mailed to the participant
    e. Email provider(s) the denial letter
7. Incomplete
    a. If required information is not received by the Regional Office within 7 working days following the request for the information from the Regional Office, the RFA will be returned to the Support Coordinator via ADIDIS and mailed to the waiver participant as incomplete
    b. The request may be resubmitted once all information is obtained
    c. Email provider(s) the letter indicating the request is incomplete
8. Copy the Support Coordinator and Support Coordinator Supervisor (upload in ADIDIS) on approval, denial, or incomplete requests

An RFA is NOT required for the following:

A team meeting is required in these instances. The process should be completed in no less than five (5) days to ensure timely delivery of Services:

1. Units currently authorized and on the Plan of Care that require a change
    a. Transfer of units between services already on the Plan of Care
    b. ADIDIS notes should be updated
2. All address changes in residential providers or provider sites
    a. ADIDIS notes should be updated and provider will submit an updated IRBI to the Community Services Director via email
3. Change in providers
    a. ADIDIS notes should be updated and provider will submit an updated IRBI to the Community Services Director via email

Procedures for Support Coordinator when an RFA is NOT Required:

1. Ensure documentation is evident in the Person-Centered Plan
2. Review authorizations to ensure the service(s) are currently authorized prior to making changes
    a. If the service is not currently authorized, an RFA will be required to add a new service
3. Make changes to the participant's Plan of Care
    a. Terminate the previous units (T code)
    b. Add the new begin date and end date for the new service(s) (A Code)
4. Submit note into ADIDIS and copy the Regional Office RFA Account
5. Support coordinator will review authorizations and notify the provider the dates of changes in service(s)

Procedures for Regional Office when an RFA is NOT Required:

1. Waiver Coordinator will verify the Plan of Care has been updated correctly
    a. If revisions or documentation is needed, return to the Support Coordinator
2. Once reviewed by Waiver Coordinator, mark the note as Complete and copy the Support Coordinator and the Fiscal Manager to authorize the service

*Note: Regional Request for Action Form (RFA) and (RFA) Instructions - *(See List of Forms Table)*

A.4.3 Redetermination

Responsible Office: Regional Community Services

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: February 14, 2022

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

Definitions: 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 uploaded to the DDD IMS **Notes** tab:
      i. Signed Person-Centered Plan
      ii. Freedom of Choice
      iii. Person Centered Assessment and Plan
      iv. Physical or RN Assessment (only until physical is obtained) (CWP use Physical Form)
      v. ICAP
      vi. Psychological
   b. 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:
      i. Signed Person-Centered Plan
      ii. Freedom of Choice
      iii. Person Centered Assessment and Plan
      iv. Physical or RN Assessment (only until physical is obtained)
      v. ICAP
      vi. Psychological
   c. Prints the Level of Care (LOC) form from the **Demographics** tab.
      i. Ensures eligibility is evidenced by at least 3 areas of life activity checked on the LOC.
   d. Prints the person's Interchange Screen and checks the **Fund Eligibility** to verify active status for Alabama Medicaid.

e. Reviews the Waiver documents in the **Clients** tab of DDD IMS [referenced tabs are in bold below]:
   i. Opens the **Diagnosis** tab to ensure information there is consistent with the IQ level on the Level of Care (LOC)
   ii. Reviews the Eligibility Assessment under the **Assessments** tab (Psychological/ICAP/ABS)
      1. Ensures it was completed within 60 days of the redetermination date.
      2. Ensures the referenced IQ score is less than 70.
      3. Ensures the referenced ICAP was completed within 2 years and review at least annually.
      4. Ensures the referenced ICAP score is less than 85.
   iii. Reviews the Summary of Habilitation record in **Assessments** to ensure the LOC limitations match identified deficits.
   iv. Reviews the **Plan of Care** to ensure the redetermination/initialed field is marked as "Yes" and to ensure Waiver services provided match those represented in **Authorizations**.

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:
      i. RO Waiver Registration
      ii. Interchange Screen
   e. 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 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 is in need of change from previous administration, the waiver coordinator will notify the Fiscal Manager.

*Note: Annual Physical Examination Form and Freedom of Choice Form - *(See List of Forms Table)*

A.4.4 Summary Program of Habilitation

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30.14 Level of Care Determination for Medicaid Waiver Programs, DDD IMS User Guide
Effective: Historical Practice
Statement: The Summary Program of Habilitation is a digital form accessible in the Assessments tab of DDD IMS.
Purpose/Intent: The Summary Program of Habilitation utilizes information collected via standard assessments to identify the assets, deficits, and maladaptive behaviors of the person, so as to establish an initial habilitation plan.
HCBS Waivers: ID, LAH
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); ICAP (Inventory for Client and Agency Planning); LOC (Level of Care form)
Procedures:

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

A.4.5 Monitoring - Individual Experience Assessment Survey

Responsible Office: Support Coordination
Reference: 2014 HCBS Rule
Effective: Historical Practice
Revised: October 20, 2021
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
Definitions: People - HCBS Waiver participants; Support Coordinators - Formerly referred to as Case Managers, employed by 310 Boards; ID waiver- Intellectual Disabilities waiver; LAH waiver- Living-at-Home waiver
Procedures:

1. Support Coordinators shall assess individuals 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, Individual Experience Assessment Survey (IEA) Form 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 timeframe.
2. For individuals currently receiving Medicaid Waiver services, the initial IEA will be completed at the time of their first annual PCP assessment/meeting scheduled after the May 1, 2019 implementation date, and annually thereafter.
3. Participants in the IEA shall include the person and his or her family members and/or representative, as appropriate. The person's input should be obtained first, with input from others involved used when the person is not able to respond to one or more of the questions independently. Service provider staff may participate as requested by the individual and his or her family and/or representative.
4. Results are submitted to the provider and the Regional Office Monitor 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 PCP by the Support Coordinator or remediation by the provider with completion verified by the Regional Office Monitor and Support Coordination Liaisons.

6. The person’s Support Coordinator, as applicable, shall address any issues regarding compliance with the HCBS Settings Rule or other concerns identified during the IEA. Each NO response should be investigated to determine if it is appropriately supported by the PCP or if it is truly Not in Compliance. Specific remediation should occur for any response that is determined to be Not in Compliance.
7. Initial surveys (original) should be forwarded to the Regional Office Monitors and Support Coordination Liaisons. Thereafter, only surveys reflecting non-compliance should be forwarded to Regional Office Monitors and Support Coordination Liaisons. Provider agency(s) shall receive copies of initial and annual assessments.

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

*Note: Individual Experience Assessment Survey (IEA) - (*See List of Forms Table)*

A.4.6 Recoupment Policy

Responsible Office: System Management
Reference: RFA Procedures
Effective: Historical Practice
Statement: Support Coordinator agency found out of compliance with the RFA procedures may be subject to recoupment of funds for repeated violations to the RFA process.
Purpose/Intent: To protect the program integrity and demonstrate financial accountability.
HCBS Waivers: ID/LAH
Procedures: Steps to protect integrity of Support Coordination service delivery relating to unit utilization.

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

A.4.7 Conflict Free Support Coordination/Case Management Services

Responsible Office: Support Coordination

Reference: CMS Regulations 42 CFR 441.301 (c) (1) (vi), Affordable Care Act

Effective: November 1, 2020

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.

Purpose/Intent:

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.
   c. 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.
   d. There are clear and accessible procedures for individuals 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.
   e. 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, individuals served and their family members, advocates, providers, DDD staff and coordinators.
   f. 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.
   g. Under no circumstances shall there be undue influence over goals, compromised individual choice of services, misaligned financial incentives, or provider self-referral.

HCBS Waivers: ID/LAH

Procedures:

1. SOLE PROVIDER CONTRACTS

    a. DDD shall amend the contract of any provider entity that has been determined to be a sole provider. The amendment shall include a statement agreeing that there will be division of support coordination services and HCBS and shall be signed by the provider.
    b. The respective DDD Regional Office shall be notified of the amendment and shall increase monitoring.
    c. Violation of the amendment shall result in automatic placement on provisional certification status and notification to the DDD Central Office.
    d. Failure to take corrective action shall result in breach of contract and initiation of the decertification process.

2. CHOICE

    a. The DDD Central Office and Regional Office shall jointly develop a disclosure form to be signed by each person to be served by the sole provider denoting their choice in service providers.
    b. The person's choice form shall include a list of all provider agencies that the person can choose to deliver services.
    c. The choice form shall be completed at the time of the person's initial eligibility determination, annually thereafter at the time of redetermination, at readmission and at any time during the person's eligibility period that a change in services occurs.
    d. The person's choice form shall be filed in the person's case file.

3. MONITORING

    a. The DDD Office of Support Coordination shall monitor an entity determined to be a sole provider at least quarterly, preferably unannounced, or at any time for cause.
    b. In addition, the Office of Support Coordination, Regional Community Services, and Office of Certification shall review the provider entity to ensure that the supervision of support coordinators and supervision of those providing services are separated administratively.
    c. All monitoring findings and reviews shall be documented by the Office of Support Coordination, Regional Community Services, and Office of Certification.
    d. Violations shall result in automatic placement on provisional certification status and notification to the DDD Central Office. Provisional status may be removed once requirements for conflict-free services are met.
    e. Failure to take corrective action shall result in breach of contract and initiation of the decertification process.

4. GRIEVANCE RESOLUTION
   a. Contact information and process to resolve problems with a support coordinator and/or support coordination shall be provided at least annually, in writing, to the person served. The person shall sign a copy of the resolution process form which shall be placed in the person's case file. A copy of the form shall also be provided to the person for his/her personal files and future reference.
   b. Contact information for ADMH-DDD offices to be used by participants in seeking resolution to problems with support coordination shall be placed in the provider location, easily visible to individuals served. Such information shall also be posted on the ADMH-DDD website.
   c. If the person served has a problem with his/her support coordinator or service coordination, the person shall contact the DDD Central Office, DDD Regional Office Director or the ADMH Advocacy Office for resolution. An investigation shall be conducted, and problem resolved by the respective office.

A.4.8 Support Coordination Guideline

Responsible Office: DDD HCBs Waiver Service Providers/Support Coordination Services/ADMH-DDD Central/Regional Offices

Reference: Alabama Administrative Code 580-5-30, Support Coordination Quality Review and Certification Standards, 4.7 Conflict Free Support Coordination/Case Management Services, AC 580-5- 30, AC 580-1-2 Administrative standards for 310 Boards, Support Coordination Scope of Service, Chapter 580-3-26, OG 7.5 Comprehensive Support Systems CSS Teams, Targeted Case Management Chapter 106.

Effective: February 1, 2022

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

Procedures:

1. **Support Coordination Agency Operational Requirements**: The following operational requirements are established for all Support Coordination Agencies:
   a. Support Coordination Agencies will comply with the operational requirements found in the Scope of Service. (*FY21 Contract: EXHIBIT DD-4 TCM: Scope of Service – Support Coordination Agency ID/LAH Waivers)*
   b. Support Coordination Agencies will comply with the Administrative Standard for 310 Boards found in AC 580-1-2.
   c. Support Coordination Agencies will provide conflict free Support Coordination/Case Management services in accordance with HCBS Setting Rule.
   d. Support Coordination Agencies 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 Support Coordinator:
   i. 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. *(ID/LAH Waiver: Appendix D)*
   ii. Support Coordinators must complete a Support Coordination training program approved by DDD and the Alabama Medicaid Agency within six (6) months of beginning employment unless training in needed before the staff can sagely provide the service. *(Scope of Service Section 5.5)*

3. **Effective Person-Centered Planning Practices:** The following practice are established for all Support Coordination Agencies:
    a. Use of most integrated setting:
        i. Service selection, as part of identifying strategies to achieve the person'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.
        ii. 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. Support Coordinators will assist people with maintaining eligibility for the waiver and provide education and support as needed.
    c. Assessment resources and procedures:
        i. Support Coordinators 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/
        ii. Support Coordination Agencies will conduct assessments using person-centered and strength-based approaches including: involving the person in all assessment activities; exploration (with the person) of preferences and what works well for the person, identification of the person's own strengths and other positive attributes, and encouragement of self-determination and self-direction. *(see SC Guideline Appendix 1)*
        iii. Assessments will be completed with the person 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.
        iv. Assessment documentation will include the person's desired outcomes, in their own words, and capture the exploration of hopes and dreams from the assessment conversation.
        v. Assessment documentation will include the agreed strategies to achieve the person's desired outcomes and meet their assessed needs related to these outcomes that will appear on the person-centered plan noting how the strategies will be implemented (including in what settings the individual selected) by the person, natural support network, community supports, and paid services and supports. In addition, any information related to the person

that address Home and Community Based Settings requirements (Setting Specific Transition to Compliance Plan) should be included.

vi. 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 person-centered plan.

vii. The Support Coordinator will schedule and hold premeeting (s) with the individual, family members, and direct support providers 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.

viii. Support Coordinators will recognize all people possess unique abilities and attributes that contribute to the achievement of their goals and independence.

- Support Coordinators will recognize all people possess unique abilities and attributes that contribute to the achievement of their goals and independence.
- Person-centered plans 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.
- Assessment and Person-Centered Planning will focus on the combination of the person'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 person 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 Support Coordinator 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 Support Coordinator or other clinical professionals.
- If a person does not agree or recognize one or more risks identified by the Support Coordinators or other clinical professionals, Support Coordinators will follow the Risk Management direction found below in this policy.

ix. A Team Meeting will occur, including the person, and legal representative if applicable, to review, discuss and finalize all aspects of the Person-Centered Plan.
    - 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.
    - Person-centered plans 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 individual, and as well as at redetermination (within 365 days).

x. The person-centered plan 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 Support Coordinator.

xi. Signed completed person-centered assessments and plans will be sent to providers.

d. Re-assessment and Monitoring:

i. Support Coordinators will assess progress as needed, but at least every 90 calendar days and document within the person-centered assessment/plan.

ii. Support Coordinators will document progress as needed at least every 90 calendar days within the progress note and quarterly narrative.

iii. Support Coordinators will document the level of progress as needed with a minimum of every 90 calendar days in the person-centered-plan. If there are no changes to the person-centered plan needed, then the Support Coordinator will update the person-centered plan, review the updated person-centered plan with the team and obtain all Team members’ signatures on the new plan.

iv. Through interviews and observations, the Support Coordinator evaluates the individual’s progress toward accomplishing the goals listed in the person-centered plan at a minimum quarterly. In addition, the Support Coordinator contacts individuals or agencies providing services 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.

v. The Support Coordinator determines what services have been delivered and whether they adequately meet the needs of the individual. The person-centered plan may require adjustments as a result of monitoring.

vi. Support Coordinators will annually assess and document updates to the person-centered plan and assessment, minimally completing the reassessment section in ADIDIS.

vii. All Person-Centered Assessment and Planning guidelines outlined above are applicable to the redetermination process (See OG A.4.3 Redetermination).

e. Back-up and contingency planning:

i. Assessment and planning documentation will include back-up and contingency exploration for situations where supports of identified strategies are not available.

ii. Support Coordinators will report lack of supports for a service to the appropriate Regional Office.

iii. Support Coordinators will work with the appropriate Regional Office to build capacity for this service.

iv. Support Coordinators will research existing providers and explore the possibility of providing the service to support the person.

v. Support Coordinators 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.

vi. All Person-Centered Assessment and Planning guidelines outlined above are applicable to the redetermination process. (See OG A.4.3 Redetermination)

f. Promotion and Protection of Individual Rights and preventing abuse of individuals:

i. Support Coordinators will implement operational practices that promote and protect the rights of individuals as defined by all applicable Federal and State of Alabama regulations, laws, acts, and other legal authority.

ii. Support Coordinators and the provider agency will participate in a discussion at the annual meeting to ensure people are informed of their rights. The Support Coordinator documents the conversation and provide a copy of the Rights & Responsibilities form to the provider agency.

iii. Support Coordinators will work with providers and communities to ensure people have meaningful work and activity choices. These choices should encourage and promote age-appropriateness, a positive self-image, and consider the person's cultural background and/or preferences. 580-5-30

iv. Support Coordinators will implement operational practices to ensure individuals receive only the level of support needed for the individual to make their own decisions, including assisting the individual to advocate for themselves.

v. Support Coordinators will provide individuals and their legally authorized representatives an oral and written summary of their rights and responsibilities and how to exercise those rights and responsibilities.
vi. Support Coordinators will maintain practices for due process, including review and documentation, in the event of a proposed restriction of an individual's rights.
vii. Support Coordinators will provide education and/or resources on voter registration and the voting process to people aged eighteen or older that express interest and assists with registering and voting, as needed.
viii. Support Coordinators obtain written informed consent from the individual or their legally authorized representative prior to:
    - any intrusive medical or behavioral intervention,
    - participation in research, and
    - sharing information about the individual.
ix. Materials presented to individuals or their legally authorized representative is provided in language the individual can understand.
x. Support Coordinators provide individualized supports/services that are free from discrimination by race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances.

g. Fraud, waste, and abuse:
i. Support Coordinators will comply with all provisions of Chapter 560-X-4.04 and Chapter 560-X.4.05.
ii. Support Coordinators will monitor the person's financial situation and ensure individuals are not paying for anything covered by a waiver service.

h. Behavioral Support Plans:
i. If appropriate, individuals have a Behavior Support Plan that reduces, replaces, or eliminates specific behaviors and are implement according to DMH-DDD's Behavioral Services Procedural Guidelines.
    - Behavior Support Plans are created by the provider agency. The provider agency will submit a copy of the Behavior Support Plan to the Support Coordinator to be documented within the Person-Centered Assessment and Plan.
    - Support Coordinator will document any restrictions or need for restraints in the Person-Centered Assessment and Plan.
    - Changes to the Behavior Support Plan are made and implemented by the provider agency with the agreement of all team members.
ii. Behavior Support Plans are approved by the 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.

iii. Behavior Support Plans are reviewed at least quarterly, or more frequently as required by the individual's needs, for effectiveness and appropriateness.

iv. Highly intrusive behavior interventions or punishment for the convenience of staff or in lieu of a Behavior Support Plan are not permitted.

i. Crisis planning and intervention:

   i. Support Coordinators will follow the CSS Team operation guideline found in OG A.7.5.

j. Risk Management:

   i. Every person has the right to make informed decisions of their choosing necessary for individual growth and development. Service Coordinators will support dignity of choice and risk, allowing for self-determination related to reasonable risks of personal choices.

   ii. The assessment, development, planning and implementation of risk mitigation strategies are discussed and agreed upon by all team members at the annual meeting.

   iii. Support Coordinators 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.
   - Documenting the risks identified and risk mitigation strategies for each person as part of the person-centered assessment and plan.

k. Natural Support Networks:

   i. Support Coordinators ensure there are a variety of methods for helping people stay connected to their natural supports.

   ii. Support Coordinators 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.

   iii. Support Coordinators ensure the person is provided education to develop and/or improve skills to support people's communication with natural supports, especially families and friends.

l. Conflict of interest:

   i. Support Coordinators will avoid conflicts of interest that interfere with the timely and effective assessment, planning, and support of people enrolled in

waiver programs.

ii. At a minimum, Support Coordinators and provider agencies will adhere to the Conflict Free Support Coordination/Case Management Services outlined in Scope of Service section 2.1.

4. **Collaboration:** Support Coordinators 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. Support Coordinators will maintain knowledge of applicable waiver service options, community resources, and a person's natural supports.
   b. Support Coordinators will identify gaps in contracted service capacity for improvement and development.
   c. Support Coordinators will address any environmental and safety concerns with provider agencies and ensure education is provided to the individual on how to mitigate any safety concerns.
   d. Support Coordinators will share pertinent information regarding the individual's support needs, including medical care, safety concerns, etc. with all applicable Support Team members.
   e. Support Coordinators will partner with paid and unpaid service providers to identify opportunities for innovative practices to implement person-centered planning.
   f. Support Coordinators will monitor the implementation of person-centered plan strategies and partner with providers to improve effectiveness and address any training gaps.
5. Self-Directed Services: Support Coordinators must complete the Person-Centered Assessment and Planning Process with all self-directed individuals. This includes the assessments (Appendix 1), person-centered assessment and plan.
6. **Documentation Best Practices: ** *Under Construction*

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 ADIDIS 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 ADIDIS and summarizes findings within the Overall Health subsection of the Healthy Living Domain
*Financial Assessment or Money Management Assessment	Complete and submit to SC	Support Coordinator completes, uploads assessment into ADIDIS and summarizes findings within the Finances subsection of the Community Living Domain
Fall Risk Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Safety subsection of the Community Living Domain
Behavior Support Plan	Complete and submit to SC	Uploads assessment into ADIDIS 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 ADIDIS and summarizes findings within the Medications subsection of the Healthy Living Domain
*Safety Assessment	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Safety subsection of the Community Living Domain
*Rights Assessment	Complete and submit to SC	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 ADIDIS and summarizes findings within the Access to Possessions subsection of the Community Domain
Lease Contract	Complete and submit to SC	Uploads assessment into ADIDIS and summarizes findings within the Living Situation subsection of the Community Living Domain
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.		

*Note: Financial Assessment and Rights Assessment forms - (*See List of Forms Table)*

A.4.9 Free Choice of Provider and Free Choice Provider Complaint/Grievance Process

Responsible Office: Support Coordination
Reference: ID/LAH HCBS Waivers
Effective: Historical Practice
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.
HCBS Waivers: ID/LAH
Definitions: FCOP (Free Choice of Provider), SC (Support Coordination)
Procedures:
<u>Free Choice of Provider</u>
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 must be completed at the time of new admission, annually and every time the person supported changes provider.
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 the document is completed and signed. SC may sign as a witness.
5. Offer a copy of the signed document to anyone who signs the document.
6. Scan the signed form into the notes of Information and Management System as a part of the redetermination packet and at the point that there is a provider change.
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

<u>Free Choice of Provider Complaint/Grievance Process</u>
The Support Coordinator must:

1. Review with the person supported and the legally authorized representative the FCOP complaint/grievance process. In the absence of a legally authorized representative and when the person permits, it should be reviewed with the responsible family member.
2. Point out that although they can call any of the phone numbers listed their call will likely be rerouted to the Region for their county of residence.
3. Provide the person a copy of the form so they will have the phone numbers readily available
4. Provide the approved, non-personalized by county form. (located on the ADMH website)

CHAPTER 5
PROVIDER REQUIREMENTS AND OTHER INFORMATION

A.5.1 New Provider Enrollment

Responsible Office: Office of Quality and Planning/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
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
Definitions:
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
        i. Application package received after sign-in and contents reviewed
        ii. 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.

9. If application package does not meet criteria, package is either returned to applicant for additional information or denied and returned to applicant. Reasons for not approving applications:
    a. Unfavorable background check for Executive Director (ED) (can reapply with new ED)
    b. Falsification of information (cannot apply again)
    c. Lack of educational background for Executive Director (can reapply with new ED)
    d. Lack of required experience (5 yrs.) for Executive Director (can reapply with new ED)
    e. Application reviewed 3 times
    f. Pattern of substantiated incidents of abuse, neglect, mistreatment, and exploitation
    g. Setting does not meet HCBS Settings Rule
    h. Presence on the Exclusion List
    i. Agency has demonstrated an inability to take on added responsibility of additional setting or service (can reapply after next favorable full review)
        i. Provisional Certification
        ii. Extended TOA (s)
    j. Previously Decertified
    k. Inappropriate name for organization (can reapply with favorable name)
10. If application package meets criteria, application is approved and sent to OCA for issuance of a Temporary Operating Authority to provide services
11. 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
2. OCA forwards the application to the Office of Quality and Planning (OQP) for review and recommendation.
3. OQP returns the application with the Application and Setting Review Form *(See List of Forms Table)*, with recommendation and any supporting documentation for all new settings, to the OCA.
4. The OQP completes part 1A and 1B. If question 1A or 1B of the form is "Yes", the application is not approved and will not be processed further. If questions 1A and 1B are "No", the OCA forwards application and form to the Regional Community Services (RCS) Office for review and recommendation.
5. RCS completes Part B and returns the application with form and any supporting documentation to the OCA who forwards to the OQP for final review. The OQP reviews application and supporting documentation.

    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 service, the application is not approved and a letter detailing the denial is returned to the OCA.
6. Life Safety completes a review.
    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 chooses to acquire new property, process starts over. Documentation/application returned to OCA.
7. OCA notifies Alabama Medicaid Agency (AMA), Office of Certification, and Associate Commissioner of the TOA.
8. Office of Certification assigns a setting number and notifies Office of Systems Management (OSM), and
   Regional Office.
9. Regional Office notifies appropriate 310 Authority for Targeted Support Coordination (TSC) so the provider can be placed, as an option, on the Free Choice of Provider List.
10. Regional Office Fiscal Staff initiates contract process and establishes a $1.00 place holder contract.

If no services are provided in the setting at the end of the 6-month certification date, the TOA must be renewed.

Phase FOUR – *New Provider Orientation*

1. 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
2. Fiscal Management
    a. Contract Process
    b. Billing and Claims
    c. IRBI
3. Community Services
    a. Provider Self-Assessments
    b. Validation/Monitoring/POA Process
    c. Special Team Meeting
    d. IPMS

    e. Nursing
    f. Regional Technical Assistance
4. Comprehensive Support Services
    a. Behavioral Support Planning
    b. Crisis Management
5. Certification
    a. Administrative Code
    b. Certification Overview
    c. HIPPA
    d. Person-Centered Planning
6. Quality Enhancement
    a. Person-Centered Thinking
    b. Fatal Five
    c. Basic Assurances (Factor 10 Training)
    d. 4-Day POM Training
7. 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
8. Advocacy & Rights Protection
    a. Rights Training/Assessment
9. 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

*Note: Application and Setting Review Form - (*See List of Forms Table)*

A.5.2 Certifications

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

Responsible Office: Office of Quality and Planning/Certification
Reference: Chapter 580-1-4 covers Administrative Standards for Providers (non-310)
Effective: Historical Practice
Revised: May 28, 2021
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
Definitions:

- Contractor: any entity having a direct contract with the Alabama Department of Mental Health (ADMH)Division of Developmental Disabilities (DDD) to provide Home and Community Based Services (HCBS) waiver services. The Contractor is responsible for Quality performance of ALL of its subcontractors, regardless of the type of agreement with the subcontractor. The Contractor must establish a continuous quality improvement (CQI) system, which complies with the standards set forth by the ADMH that includes ALL of its sub-contractors
- Subcontractor: any entity that enters into an agreement or contract with an Agency that directly contracts with ADMH-DDD to provide HCBS waiver services
- Standalone subcontractor: a sub-contractor who contracts with a contractor for waiver claims billing only. A Standalone subcontractor must be designated as such and must be certified to provide HCBS waiver services
- OCA – Office of Certification and Administration

Procedures:
When the provider's provisional status is removed, ADMH-DDD will only approve a 'replacement' setting if it meets all normal requirements (approval by OCA, Office of Quality and Planning and Life Safety) for a setting's approval. 'New' settings will not be approved until the provider completes two successful certifications (see below). Please note, Regional Offices do not make the final determination on whether a setting is approved. Final determination on whether a setting is approved is made by the Office of Certification in Montgomery. They 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.

NOTE: When a provider is in provisional status, said provider cannot be referred individuals to serve nor accept new individuals, add a new setting nor new service. Once provisional status is removed, they may receive referrals to serve and accept new individuals into a setting.

ADMH-DDD will not approve additional settings or services, following a provisional certification, until the provider successfully completes two regular (Full programmatic) certification reviews. The certification process, once a provider receives provisional status, is as follows:

1. Regional Offices MUST verify the provider is in good standing and can accept referrals for individuals to be served.
2. Regional Offices MUST verify the provider is in good standing before visiting any proposed new setting.
3. Provider receives provisional status for deficiencies noted during their regular/full programmatic certification review.
4. Within 60 days of the review, a certification follow-up is provided to determine if the provisional status should be removed. NOTE: ONLY deficiencies cited during the previous regular/full certification review that warranted the provisional status will be reviewed during 60-day follow-up.
5. If the deficiencies are determined corrected during the 60-day follow up, the provisional is removed and a regular/full certification review is scheduled one year from the regular certification date.
6. If the deficiencies are determined not to be corrected during the 60-day follow up, the provisional is extended another 60 days and another follow up is scheduled.
7. If the second follow-up determines deficiencies remain, depending on the severity the deficiencies, the provisional can be extended or the provider may be recommended for decertification.
8. NOTE: Additional extensions may be granted depending on the nature of the deficiencies and the provider's progress towards successfully addressing the deficiencies. DMH Staff must ensure technical assistance is provided to assist the provider to resolve deficiencies. Mandated technical assistance is warranted any time deficiencies are related to Health, Safety and Abuse, Neglect, Mistreatment, and Exploitation.
9. If the follow-up determines all deficiencies are corrected, the provisional status is removed, and the provider must achieve successful certification in TWO REGULAR (full program) certification reviews according to the Office of Certification and Administration's (OCA) two-year certification cycle.
10. A one- or two-year certification following a provisional status is based on the provider's certification score AND the OCA's certification cycle.

EXAMPLE OF CERTIFICATION WITH PROVISIONAL:
Contractor (with or without subcontractors (excluding standalone subcontractor) receiving TWO successful regular reviews following a Provisional certification:

- Provider received provisional April 2018 after a regular certification review.
- The provider came off provisional in June 2018 and received a one-year certification. The provider will need TWO regular/full reviews before they, or their sub-contractors (excluding standalone sub-contractors) can add new settings.
- April 2019 – the provider successfully achieved a review that did not place them in provisional status. This successful review will be considered the FIRST of TWO regular, successful certifications following a provisional status.
- April 2020 – the provider successfully achieved a review that did not place them in provisional status. This certification review is the SECOND regular full review with no deficiencies noted that would place them in a provisional status. After this SECOND successful regular review, the contractor will receive a 1- or 2-year certification based on their certification score and OCA's certification schedule the provider is now approved to request new settings.

Contract and/or Standalone Subcontractor receiving one successful review following a provisional, then another provisional, followed by two successful regular reviews:

- Oct 2017 a provisional status was given due to deficiencies; Deficiencies were corrected by 60 day follow up and provisional was removed in Feb 2019. A 1-year certification was granted
- Oct 2018 a regular/full certification is provided, and no deficiencies are noted that warrant a provisional status, this review will count as the FIRST certification granted after provisional status and they will receive a 1- or 2-year certification based on their certification score and OCA's certification schedule.
- Oct 2019 a provisional status was given due to deficiencies; Deficiencies were corrected by 60 day follow up and provisional was removed in Feb 2019. A 1-year certification was granted
- Oct 2020 – the provider successfully achieved a review that did not place them in provisional status. This successful review will be considered the FIRST of TWO regular, successful certifications following a provisional status and the contractor/standalone provider will receive a 1- or 2-year certification based on their certification score and OCA's certification schedule
- Oct 2021 – the provider successfully achieved a review that did not place them in provisional status. This certification review is the SECOND regular full review with no deficiencies noted that would place them in a provisional status. After this SECOND successful regular review, the contractor/standalone provider will receive a 1- or 2-year certification based on their certification score and OCA's certification schedule, the provider is now approved to request new settings.

A.5.2.b Temporary Operating Authority (TOA) Process

Responsible Office: Office of Quality and Planning/Certification

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

Effective: Historical Practice

Revised: September 17, 2020

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

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

HCBS Waivers: ID, LAH

Definitions: Certification Administration (OCA), Regional Community Services (RCS)

Procedures:

1. The provider submits an application for a new setting or service, Application and Setting Review Form *(See List of Forms Table)* to the Office of Certification Administration (OCA).
2. The OCA logs application pack and criminal background check notification from BSI.
3. The OCA forwards the application to the Office of Quality and Planning (OQP) for review and recommendation.
4. OQP returns the application with the Application and Setting Review Form, with recommendation and any supporting documentation for all new settings, to the OCA.
5. The OQP completes part 1A and 1B. If question 1A or 1B of the form is "Yes", the application is not approved and will not be processed further. If questions 1A and 1B are "No", the OCA forwards application and form to the Regional Community Services (RCS) Office for review and recommendation.
6. RCS completes Part B and returns the application with form and any supporting documentation to the OCA who forwards to the OQP for final review. The OQP reviews application and supporting documentation.
   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 service, the application is not approved and a letter detailing the denial is returned to the OCA.
7. For a new setting, the OCA forwards requirement to Life Safety inspection for scheduling.
   a. Life Safety completes a review.
      i. Setting passes: Life Safety review, documentation/application returned to OCA.
      ii. Setting does not pass: Provider given opportunity to correct deficiencies, if possible, or can opt to acquire another property. If provider chooses to acquire new property, process starts over. Documentation/application returned to OCA.
   b. The OCA prepares a letter of TOA for new setting and new service for the Commissioner's signature.
   c. The OCA sends TOA to provider, OQP, and Medicaid.
   d. The OQP notifies RCS and the Central Office Application Support Specialist of the TOA and provides a new setting/new service number.

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

A.5.3 New Provider Enrollment with Alabama Medicaid Agency

Responsible Office: System Management
Reference: Administrative Code 580-5-30-.13; Alabama Medicaid Provider Manual, OG# 4.1
Effective: Historical Practice
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
Definitions: DDD IMS (Division of Development Disabilities Information Management System)
Procedures: Once a new provider has been certified or receives a temporary operating authority (TOA), notification is sent to the appropriate regional office.

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

A.5.4 Validation of Provider HCBS Self-Assessment

Responsible Office: Regional Community Services

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

Effective: Historical Practice

Revised: February 11, 2020

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

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

HCBS Waivers:

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

Procedures:

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

5. The Provider will have 15 business days to complete the Setting Transition-to-Compliance Plan, providing methods and timeframes for resolving all validation findings for the setting demonstrating non-compliance or partial compliance with the HCBS Settings Rule.
    a. During a validation visit by the Regional Monitor, any incidental findings that directly impact rights, restrictions, health, safety and/or security of individuals served must be resolved by the Provider in advance of submission of the Setting Transition-to-Compliance Plan and submitted separately to the Monitor by email, to include date and method of resolution, along with accompanying substantiating documentation.
    b. Upon receipt, the Regional Monitor reviews the Setting Transition-to-Compliance Plan to ensure that it adequately addresses all validation findings and then submits it to the CSD/designee.
        i. If the Setting Transition-to-Compliance Plan does not address all validation findings or does so inadequately, the Regional Monitor provides that feedback to the Provider via email within 15 business days, copying the Community Services Director (CSD)/designee.
        ii. The Provider then has 10 business days from the date this feedback is delivered to correct the plan and re-submit.
        iii. The Regional Monitor will contact the Provider about the revised plan within 15 business days.
    c. If the Provider comprehensively resolves some validation findings prior to submission of the Transition-to-Compliance Plan, these findings are still to be included in the Setting Transition-to- Compliance Plan with date and method of resolution, along with accompanying substantiating documentation.
    d. If the Setting Transition-to-Compliance Plan is not submitted, the Regional Monitor will inform the Community Services Director/designee on the 16th day, and the CSD/designee will contact the Provider immediately to request submission.
    e. In the event the Setting Transition-to-Compliance Plan 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 and the need for additional substantiating information will be mailed quarterly until 6/30/22.
    f. Once the Setting Transition-to-Compliance Plan is received and deemed complete by the Regional Monitor, they will notify the CSD/designee that it is available for review.
6. The CSD/designee will review/approve the Provider Transition-to-Compliance Plan within 7 business days of receipt of the completed plan.
    a. If the Setting Transition-to-Compliance Plan is not submitted within specified timeframes or is not accepted upon resubmission, the Regional Office will require the Provider to participate in assigned Technical Assistance pertinent to the identified area(s) of concern.
    b. The Provider will be given 30 days to complete the Technical Assistance and re-submit the Setting Transition-to-Compliance Plan.
7. The Regional Office will meet with all Regional Monitors (to include QE, Certification, or any regional office staff) at least monthly, to discuss the Setting Transition-to-Compliance Plans, so

as to identify Providers demonstrating difficulty transitioning to HCBS compliance, note cross-Provider trends in compliance, identify areas of needed technical assistance, etc.

8. The Regional Office will collect data on each setting's compliance with each part of the rule as evidenced by the Setting Transition-to-Compliance Plans and progress made on resolving each of the findings identified and provide monthly reports of such to the Director of Planning and Quality Enhancement for those settings completed during that particular month.
9. The CSD/designee will coordinate Technical Assistance with the Provider, to be completed by corresponding DMH staff, as assigned.
10. After completion of the validation review, the Regional Monitor will follow the same process within six months to review the assigned setting again and review specific progress achieved or not achieved with regard to the approved Setting Transition-to-Compliance Plan.
11. Thereafter, and until September 30, 2021, the Regional Monitor will twice annually utilize an HCBS Validation Check List during routine monitoring to ensure that the Provider remains in compliance with the HCBS Settings Rule.

A.5.5 Monitoring of Waiver Services

Responsible Office: Regional Community Services
Reference: ADMH Administrative Code 580-3-23-.13 through 580-3-23-.15
Effective: Historical Practice
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
Definitions: CMS (Centers for Medicare and Medicaid Standards); RCS (Regional Community Services); CSD (Community Services Director); POA (Plan of Action); DDD (Division of Developmental Disabilities)
Procedures:

1. The Regional Monitor monitors every certified DMH/DD setting twice annually, once each during periods April 1 – September 30 and October 1 – March 31.
2. The Regional Monitor arrives to the setting unannounced, if possible. In the event two unannounced visits are attempted at disparate times, but no one is available at the setting, the Regional Monitor may contact the Provider directly to arrange a time when Waiver-served individuals and Provider staff members will be present.
3. The Regional Monitor uses the corresponding Monitoring Tool (e.g., Residential, Day, or Supports) to complete the monitoring assignment, comprehensively addressing each item included and verifying with direct observation of substantiating documentation, interviews, and/or visual inspection, as appropriate.
4. In the event the monitoring visit yields findings that indicate immediate risks to health, safety or security, the Regional Monitor will immediately notify the Community Services Director (CSD) for determination of a safe and appropriate time frame for addressing the emergent finding(s) (e.g., 24 hours, immediately, etc.). It may be that the individuals 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 individuals served at the setting must be relocated until they are addressed.
5. The Regional Monitor completes the monitoring report and transmits to the Provider via email within ten (10) business days, delineating those findings requiring follow-up. The CSD/designee is to be copied on this email.
6. If the Provider receives a monitoring report that requires follow-up response(s), the Provider must address those findings and respond directly to the Regional Monitor within ten (10) business days with evidence of resolution for each.
    a. Note that any emergent findings that were resolved during or before that 10-day period must be reflected in the Provider's response as resolved.
    b. If there are findings that require more than 10 business days to resolve, the Provider is required to submit to RCS within the allotted 10 business days a Plan of Action (POA) for those findings, to include method and specific time frame of resolution.
7. If there are no findings requiring follow-up, or when all findings are fully and satisfactorily addressed, the Regional Monitor provides the closed monitoring report and, as applicable,

substantiating documentation/evidence to the CSD/designee for review and notation of completion.

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

A.5.6 Monitoring of Special Staffing

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

1. The Behavioral and Psychological Evaluator maintains a comprehensive list of each Waiver-served person restricted with special staffing, whether for behavioral or medical reasons. This list includes the name of the Residential or Day provider responsible for the special staffing, as well as the physical address of the setting, the required staffing ratio (e.g., 1:1, 2:1, etc.), and the dates of approval and expiration of the special staffing restriction.
2. The Behavioral and Psychological Evaluator updates the special staffing list weekly, as special staffing for various 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: Regional Community Services
Reference: Administrative Code 580-5-30-.02
Effective: Historical Practice
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.
HCBS Waivers: ID, LAH
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 or conducted virtually.
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: Office of Quality & Planning
Reference: ADMH Administrative Code 580-5-30
Effective: Historical Practice
Statement: By following this process, providers will have all the necessary information required to when making a name change for their organization.
Purpose/Intent: To provide a process for agencies wanting to change their name.
HCBS Waivers: ID/LAH
Definitions: Division of Developmental Disabilities Information Management System (DDD IMS); Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DDD)
Procedures:

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

A.5.9 New Systems Software Releases

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

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

A.5.10 Direct Service Provider Operational Requirements

Responsible Office: Support Coordination (Case Management)

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: April 1, 2023

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

Definitions: 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:

i. The provider agency implements policies and procedures that clearly define its commitment to and addresses the promotion and protection of individual rights.

ii. 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.

iii. The provider agency provides individualized supports/services that are free from discrimination (race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances).

iv. 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.

v. 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.

vi. The provider ensures all staff are trained to recognize and honor people's rights.

vii. The provider agency upholds due process requirements and follows

applicable procedures.

viii. The provider agency implements a formal grievance policy and procedure and informs individuals of the policy annually.

ix. The provider agency has access to a working and effective Human Rights Committee.

b. Dignity and Respect:

i. Provider agency policies and procedures ensure people are treated as people first.

ii. Provider agency staff respect the concerns of individual’s supported and have a system in place to respond to the individual’s concerns accordingly.

iii. Provider agency ensure individuals have privacy in their sleeping or living unit.

(1) 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.

A. 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.

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

(3) Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

iv. Providers ensure all supports and services enhance dignity and respect and that individuals are free from coercion and restraint.

v. Providers work with Support Coordinators and communities to ensure people have meaningful work and activity choices.

vi. 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

i. The Provider agency implements policies and procedures that define, prohibit, and prevent abuse, neglect, mistreatment, and exploitation and ensure support staff are properly trained.

ii. 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:

i. The provider agency ensures people have support and access to manage their own health care.

ii. The provider agency ensures health needs are addressed in a timely manner.

iii. Provider agency staff immediately recognize and respond to medical emergencies and inform Support Coordinators about any changes in health status

iv. The provider agency ensures people receive medications and treatments safely and effectively.

v. The provider agency has policies and procedures that are in accordance with the Alabama Board of Nursing Regulations.

e. Safe Environments:

i. The provider agency provides individualized safety supports as outlined within the PCP.

ii. The provider agency protects people from abuse, neglect, mistreatment, and exploitation and follows all procedures within the IPMS.

iii. The provider agency ensures the physical environment promotes people's health, safety, and independence.

iv. The provider agency has individualized emergency plans.

v. The provider agency conducts routine inspections to ensure environments are sanitary and hazard free.

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

f. Staff Resources and Supports:

i. The provider agency ensures staff are trained on Quality Improvement, PCP foundations, and PCP implementation strategies.

ii. The provider agency implements a system for staff recruitment and retention that is in accordance with all applicable laws and agency requirements.

iii. The provider agency implements policies and procedures that promote continuity and consistency of staff.

g. Positive Services and Supports:

i. The provider agency ensures people are informed about the services and supports they provide.

ii. The provider agency providers continuous and consistent services and supports for each person as outlined in the PCP.

iii. The provider agency monitors and reports the effectiveness of each support and service they provide as outlined within the PCP.

iv. The provider agency provides positive behavioral supports to people and

ensures people are free to unnecessary, intrusive interventions.

v. The provider agency treats people with psychotropic medications for mental health needs consistent with standards of care.

h. Continuity and Personal Security:

i. The provider agency has a governing board and leadership team that provides transparent guidance and direction

ii. The provider agency has clear mission and value statements aligned with person-centered planning philosophy they are accountable to.

iii. 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.

iv. The provider agency has business, administrative, and support functions that comply local, state, federal requirements.

v. The provider agency has a cumulative record of personal information that upholds confidentiality and promotes continuity of services.

i. Quality Improvement System:

i. 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.

ii. The provider agency has monitoring data that is accessible and used for continuous learning and improvement.

j. Conflict of interest:

i. Provider agencies have a conflict-of-interest policy and procedure.

ii. 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:

i. 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.

ii. 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:

i. 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/

ii. Providers Agencies will provide information in a strength-based way to the Support Coordination agencies during the person-centered planning discussions.

iii. 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.

iv. 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).

v. 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.

i. 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.

ii. Providers are to participate in the Team meeting by sharing their strategies to support individual in obtaining his/her outcomes.

iii. Providers are to share quarterly updates with data identifying progress towards the goals

vi. 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:

i. Provider agencies ensure there are a variety of methods for helping people stay connected to their natural supports.

ii. 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.

iii. 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:

i. 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.

ii. 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.

iii. Behavior Support Plans are reviewed at least quarterly, or more frequently as required by the individual's needs, for effectiveness and appropriateness.

iv. 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:

i. Provider agencies will follow the CSS Team operation guideline found in OG A.7.5.

f. Risk Management:

i. 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.

ii. 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.

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 orMoney 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 orPsychotropic 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. * These documents are always required regardless of services received. For Self- Directed Supports, the Support Coordinator is responsible for completing these forms. Appendix 2: PCP Timeline (See Attached) Appendix 3: Functional Assessment (See Attached) Appendix 4: Financial Assessment (See Attached) Appendix 5: Rights Assessment(See Attached) Appendix 6: Safety Assessment (See Attached) Appendix 7: Employment Survey (See Attached)		

A.5.11 HCBS: Provider Owned and Controlled Properties

Responsible Office: Support Coordination (Case Management)
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
Definitions:
1. 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.

2. Residency Agreement: The document that evidences the complete terms under which parties have agreed as attested by their signature.
3. 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.
4. Residential Home: The provider owned, and controlled setting chosen by the individual to receive HCBS Waiver services.
5. Provider: The owner and operator of the residential home.
6. 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.
7. Legal representative: The individual's/tenant's court ordered legal representative that must sign along with or on behalf of the Individual.
8. 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.
9. Appeals Process for Adverse Actions – Service Decision and Informal Conference – Services: The operational guidelines to address actions that may negatively impact the waiver participant.
10. Request for Action (RFA): A form completed by the Support Coordinator to request approval from the regional office when there is a need for a change to services being provided.
11. HCBS: Home and Community Based Services.
12. ADMH-DDD: Alabama Department of Mental Health-Division of Developmental Disabilities

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:
        i. 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
        ii. 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.
        iii. 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.

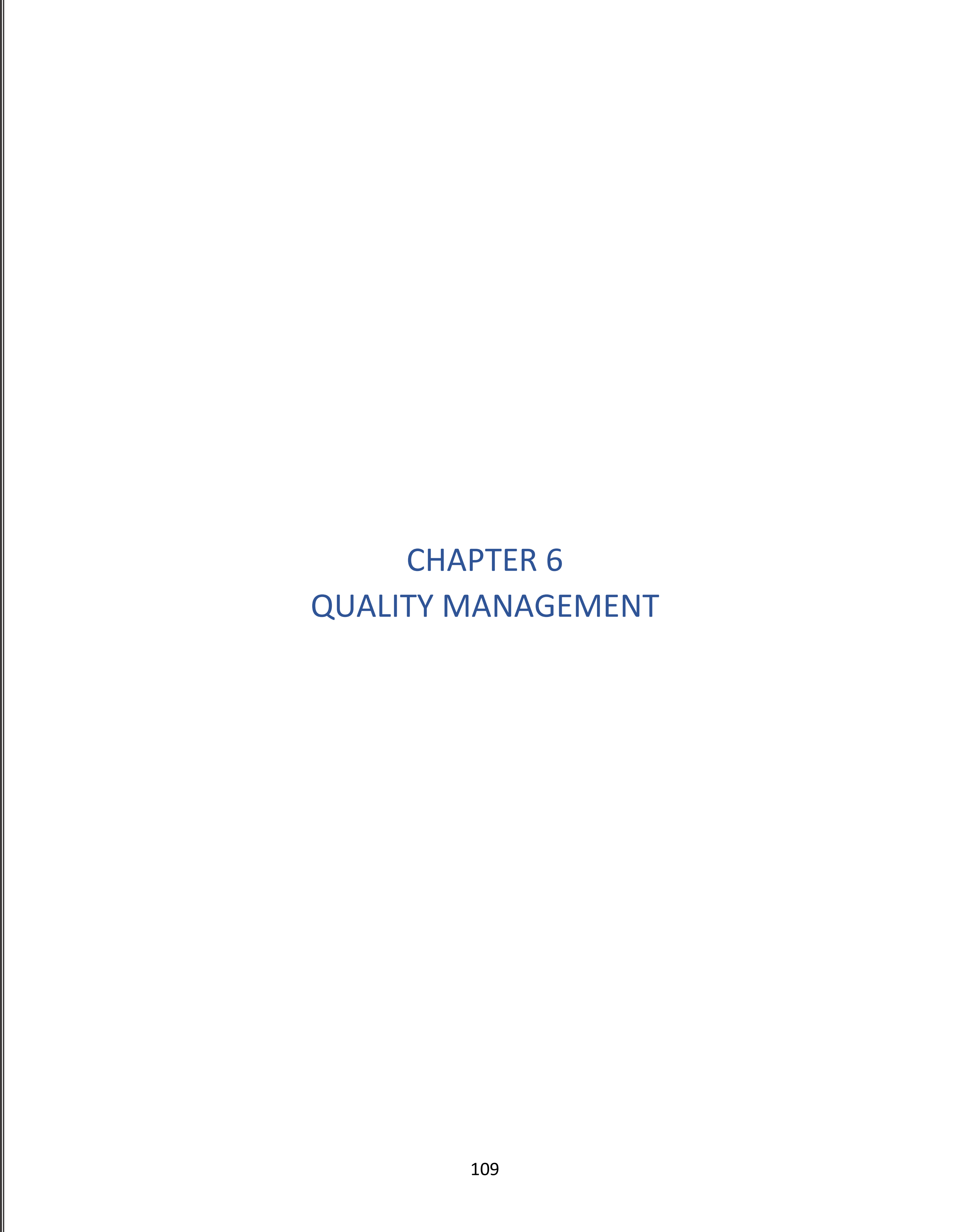
    b. The Division has developed lease/rental or residency agreement guidelines that are attached to this OG. Providers lease and or residency agreement must include all requirements as described in the attached guidelines.

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.



CHAPTER 6
QUALITY MANAGEMENT

A.6.1 Certification Review Process

Responsible Office: Quality and Planning/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
Definitions: Factor- The main topic in the administrative and support requirements for community providers of services. Indicator-Used to set expectations for each factor. Probe-Used to evaluate how well the organization meets each indicator.
Procedures:
It is strongly recommended providers complete a self-assessment using the "Assessment Tool for 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.

A.6.2 Provider Training and Technical Assistance

Responsible Office: Quality and Planning
Reference: ADMH Administrative Code 580-5-30-.11; Assessment Tool for Certifications Reviews
Effective: Historical Practice
Revised: April 23, 2021
Statement: Quality Enhancement specialists provide training and technical assistance to community provider organizations in various system areas as required by the Division of Developmental Disabilities.
Purpose/Intent: This procedure sets out to identify areas in which service providers may need assistance with agency-specific processes, training and the development of policies and procedures to improve the quality of individual and organizational supports.
HCBS Waiver: ID/LAH
Definitions: Quality Improvement System: The internal monitoring system measures the most important elements and key functions of the organization. Data sources, methods for data collection and the type of data analysis to be performed are clearly identified for each function measured. Qualified Developmental Disabilities Professionals (QDDP) is a DD professional with at least one year of experience working directly with individuals with ID, holds a bachelor's degree in a human service field, and has completed a series of required training as referenced in the ADMH Administrative Code.
Procedures: Regional QE staff provide training and technical assistance in the following areas:

1. Quality Improvement System
    a. Alabama, in partnership with CQL, re-designed and implemented new Administrative and Support Requirements for Community Providers of Services for Individuals with Developmental Disabilities, effective January 14, 2021.
    b. 580-5-30 requires that the organization has a system of internal monitoring that measures compliance with basic assurances and is designed to enhance quality.
        i. The organization monitors Quality Improvement.
        ii. A comprehensive plan describes the methods and procedures for monitoring Quality Improvement.
        iii. Quality Improvement monitoring data is used for continuous learning and improvement.
2. QDDP Training
    a. The Council on Quality and Leadership has developed these 9 training modules for human service providers in Alabama, in partnership with the Alabama Department of Mental Health/Division Developmental Disabilities. The password can be obtained from the Office of Quality and Planning and the curriculum can be accessed at https://c-q-l.org/ALtraining
        - QDDP Overview
        - Health, Safety, and Medical
        - Overview of Assessments
        - Know Your Rights
        - Nurse Delegation
        - Person-Centered Planning
        - Administrative Code
        - Incident Prevention and Management System

- Behavioral Support Planning

3. Incident Prevention and Management System
    a. Falls
    b. Medication Errors
    c. Abuse
    d. Neglect
    e. Exploitation
    f. Intimacy and Personal Relationships
4. Fatal Five
    a. Aspiration
    b. Bowel Obstruction
    c. GERD
    d. Seizures
    e. Infection/Sepsis

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

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

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

Region I Quality Enhancement Region I Community Services
Phone: (256) 552-3712
Fax: (256) 355-0551
Cell: (256) 566-5729

Region II Quality Enhancement Region II Community Services
Phone: (205) 554-4309
Fax: (205) 554-4340
Cell: (205) 792-9427

Region III Quality Enhancement Region III Community Services
Phone: (251) 478-2770
Fax: (251) 450-3798
Cell: (251) 751-0139

Region IV Quality Enhancement Region IV Community Services
Phone: (334) 676-5584

Fax: (334) 676-5591
Cell: (334) 312-5637
Region V Quality Enhancement Region V Community Services
Phone: (205) 916-7764
Fax: (205) 916-7810
Cell: (205) 215-1384

A.6.3 Developmental Disabilities Certification Policy and Procedure Requirements

A.6.3.a Non-Waiver Home and Community Based Services (HCBS)

Responsible Office: Quality Management
Reference: Alabama Administrative Code 580-1-4, 580-2-9,580-2-20, 580-3-25, 580-3-26, 580-5-30
Effective: October 1, 2020
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
Definitions: •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. • 2014 HCBS Settings Rule – Federal Regulations set forth for HCBS Waiver Services/Settings.
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:

1. Protection from abuse, neglect, mistreatment, and exploitation.
2. Best possible health.
3. Safe environments.
4. Staff resources and supports
5. Positive services and supports.
6. Continuity and personal security.
    a. Policies and procedures to address the overall requirements of the governing body, business, and administrative supports of the individuals served.
    b. Policies and procedures to address fiscal practices in managing individuals' funds and other personal resources.

c. 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.

7. 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: Quality Management

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:

Definitions: Home and Community Based Services (HCBS) Settings Rule - The Centers for Medicare and Medicaid Services (CMS) issued the HCBS Settings Rule to require that every state ensure services delivered to individuals with disabilities living in the community meet minimum standards for integration, access, to community life, choice, autonomy, and other important protections.

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
        i. 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

ii. 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.

iii. Manage money

iv. Send and receive mail including a private place to read and open mail.

v. Privacy to make and receive phone calls and use other means of communication.

vi. 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.

vii. Access individual possessions.

viii. Vote and otherwise participate in the political process.

ix. Make choices about religious affiliation and participation.

x. Interact socially with members of either gender.

xi. Privacy including a choice of private bedroom or choice of a roommate with furnishings positioned to maximize privacy.

xii. Access to food at any time

xiii. 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:
      i. Understand and support individuals' preferences in regard to rights,
      ii. 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:
    i. Any procedures for placing a limitation or restriction on an individual's rights'
    ii. 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:
        i. Current and/or former service users,
        ii. Family members of service users,
        iii. Representatives of community support and advocacy organizations,
        iv. Local official,
        v. Citizens at large,
        vi. Performance Improvement/Quality Enhancement staff (ex-officio)
    f. The HRC does the following:
        i. Makes recommendations to promote individuals' rights,
        ii. Proactively promotes and protects individuals' rights,
        iii. Reviews reports of substantiated allegations of abuse, neglect, mistreatment and exploitation,
        iv. Reviews other data that reveals practices with respect to human, civil and legal rights,
        v. Reviews research projects involving human participation to ensure the protection of the individuals who are involved,
        vi. Assists on the review of rights related policies and procedures,
        vii. Promotes rights related education and training programs,
        viii. Reviews rights restrictions,
        ix. 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: Quality Management
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.
        i. Courteous practices towards individuals,
        ii. The avoidance of labels to describe individuals based on physical characteristics or disabilities,
        iii. The practice of addressing individuals by their preferred names,
        iv. Privacy in an individual's bedroom with furnishings selected and arranged by the individual, and
        v. 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:
        i. speak or interact with others in private
        ii. 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:
        i. providing supports for bathing, dressing and personal hygiene in a private manner, and
        ii. 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:
        i. ensure healthy hygiene and personal cleanliness
        ii. choose clothing that is clean, fashionable, and fits
        iii. 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:
        i. identify preferred work and activities,
        ii. 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: Quality and Planning/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
Definitions: 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 individual.
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:
      i. provides choices about extent and frequency of contact with their natural support networks.
      ii. ensures inquiries from those in individuals' natural support systems are responded to in a natural and timely manner.
      iii. 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 of the individual's natural support network.

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

Responsible Office: Quality and Planning/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:
    i. The abuse occurred before they entered into the organization's system of services or
    ii. 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:
    i. if the occurrence of such an incident may have been the result of neglect and/or
    ii. 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: Quality and Planning/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:
      i. Individuals are given the opportunity to choose health care providers as desired.
      ii. Individuals are supported to make their own health care appointments and choices regarding their medical care as needed.
      iii. 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.
      iv. Individuals have access to all their health care records.
      v. An Individual's preferences and ability to self-administer medications and treatments are assessed at least annually in compliance with the Nurse Delegation Program.
      vi. Supports are available to assist individuals with medications and treatments if necessary.
      vii. 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.
    i. Medications are stored under lock and key.
    ii. All narcotic medications, Schedules 2, 3, 4, and 5 are stored under double lock and key.
    iii. Medications are stored separately from non-medical items.
    iv. Medications are stored under proper conditions of temperature, light, humidity, sanitation, and ventilation.
    v. Internal and external medications are clearly labeled as such and stored separately from each other.
    vi. 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.
    i. 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.
    ii. 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:
    i. 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.
    ii. 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.
    iii. 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: Quality and Planning/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.
d. 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: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
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 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
Definitions: Tuberculosis (TB)- a potentially serious infectious disease that mainly affects the lungs, cause by bacteria (Mycobacterium tuberculosis); Qualified Developmental Disabilities Professionals (QDDP) is a Developmental Disability professional with at least one year of experience working directly with individuals with intellectual disabilities, holds a bachelor's degree in a human services field, and has completed a series of required training as referenced in the ADMH Administrative Code.
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:
        i. Convictions for any crime of violence
        ii. Convictions for any felony
        iii. 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. Employees who directly provide supports to individuals will be at least 18 years of age and have the educational background and licensing credentials as required by the funding source, state law, and federal law.
      i. Residential care direct support employees will have a minimum of a high school diploma or GED/High School Equivalency Certificate.
      ii. Personal care direct support employees must be able to read and write and follow instructions.
      iii. Respite care direct support employees must have at least completed tenth grade and must be able to read and write and follow instructions.
      iv. Day habilitation direct support employees must be able to read and write and follow instructions
      v. Adult companion services direct support employees must have the ability to read and write and follow instructions.

b. 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.
c. 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.
d. 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.
e. 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.
f. 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:
      i. Rights of individuals served
      ii. HCBS Settings Rule
      iii. Complaint/grievance procedure
      iv. Policies and procedures regarding abuse, neglect, mistreatment and exploitation
      v. Overview of intellectual/developmental disabilities
      vi. Infection control/universal precautions
      vii. Severe weather preparedness
      viii. 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:
    i. CPR (must receive certification)
    ii. First aid (must receive certification)
    iii. Medical emergencies
    iv. Management of aggressive behavior
    v. Medication training including medication side effects
    vi. Signs and symptoms of illness
    vii. 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:
    i. Agency policy and procedures
    ii. Philosophy of self-determination
    iii. Person-centered supports
    iv. General behavioral principles with emphasis on skill acquisition and behavior reduction techniques
g. The organization will annually provide refresher training for all employees in each of the following areas:
    i. Rights of individuals served
    ii. HCBS Settings Rule
    iii. Complaint/grievance procedure
    iv. Policy and procedures on abuse, neglect, mistreatment and exploitation
    v. Infection control/universal precautions
h. All direct support staff will be provided annual training in management of aggressive behavior.
i. Medication Assistant Certified (MAC) trained employees will be evaluated in compliance with the Nurse Delegation Program.
j. The staff training program will be developed based on input from individuals supported and their families/legally authorized representatives
k. Staff training will reflect current best practices
l. Training for staff will include one or more of the following:
    i. Mentoring
    ii. On the job support
    iii. Personal growth and development planning or Competency based measurement
m. 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: Quality and Planning/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:

Definitions: Behavioral Services Procedural Guidelines (BSPG)- Provides information and guidance for developing and implementing behavioral services for individuals.

Psychological and Behavioral Services (PBS) Describes several behavior support procedures and ranks them in terms of their restrictiveness. The PBS is found within the BSPG. Both are referenced in this Operational Guideline. Person-Centered Plan (PCP)

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:
        i. a Qualified Developmental Disabilities Professional (QDDP)
        ii. the legally authorized representative or advocate as needed,
        iii. family members (as desired by the individual and/or legally authorized representative),
        iv. 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:
        i. individual's preferences,
        ii. family/home situation,
        iii. health needs,
        iv. activities of daily living,
        v. vocational needs,
        vi. communication skills,
        vii. leisure activities,
        viii. physical supports, i.e., adaptive equipment, and
        ix. 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: Quality and Planning/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:
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:
      i. written board approved operational policies
      ii. articles of incorporation (or a charter) with bylaws
      iii. a current organizational chart that is updated regularly, but at least annually, and identifies the titles of employees
      iv. 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.
   m.

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:
        i. 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
        iii. 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: Quality and Planning/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:
        i. Promotion and protection of individual rights.
        ii. Dignity and respect practices.
        iii. Promotion of natural supports.
        iv. Protection from abuse, neglect, mistreatment, and exploitation, including implementation of an incident prevention and management system.
        v. Best possible health, including implementation of the Nurse Delegation Program.
        vi. Safe environments.
        vii. Staff resources and supports.
        viii. Positive services and supports, including implementation of the Behavioral Services Procedural Guidelines.
        ix. 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: Quality and Planning/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
Definition: EVV (Electronic Visit Verification)
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:
        i. 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.
        iii. 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 System (IPMS)

Responsible Office: Quality and Planning/Certification
Reference: Alabama Administrative Code 580-5-30
Effective: December 1, 2020
Statement: Incident management serves to promote an environment free from harm. The Division is committed to the following beliefs:

- Individuals are entitled to appropriate services in a caring environment that promotes dignity, respect, and is free from harm.
- Providers must eliminate, wherever possible, the occurrence of preventable incidents and respond appropriately to all types of incidents.
- The fewer the number of incidents, particularly serious incidents, the more caring the environment will be for individuals to live, work, and learn there.

In 2016, ADMH adopted THERAP Services, a web-based service organization that provides a solution for documentation, communication, and incident reporting needs for agencies providing support to individuals with DD. DDD providers use this tool to submit reportable incidents to RCS offices, and other appropriate entities. In THERAP, reportable incidents are referred to as General Event Reports (GER), and completed investigations are referred to as GER Resolutions.

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 individuals receiving waiver services.
Purpose/Intent: To protect the program integrity and demonstrate financial accountability. The purpose of the community Incident Prevention and Management System (IPMS) is to describe and implement through standard actions by the Division of Developmental Disability Services, its Regional Community Services (RCS) offices, and contractors, a mechanism to protect individuals served 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.
HCBS Waivers: ID/LAH
Definitions: An incident is any unplanned occurrence that has the potential to affect the health, safety, and welfare of individuals served by the DDD.

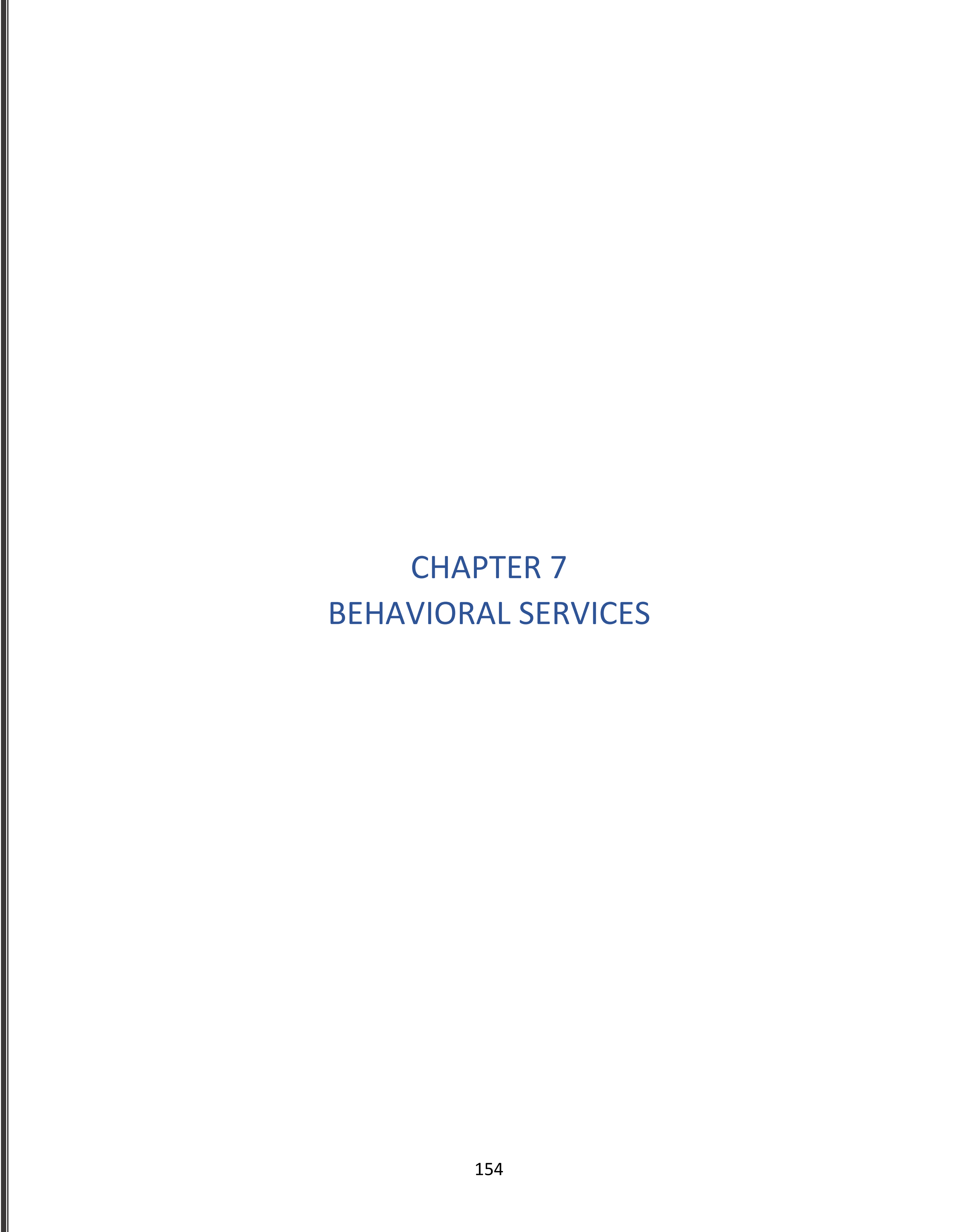
Pursuant to the IPMS, the following are considered reportable incidents: medical emergencies including moderate injuries, severe injuries, choking, seizures, falls, and unscheduled hospital admissions, medication errors, AWOL/Missing person, death, behavioral issues, natural disasters, fire, allegations of abuse, neglect, mistreatment, or exploitation, physical assault, sexual assault, manual restraint, mechanical restraint, chemical restraint, and other occurrences which require the notification of Police, or DHR.
Critical incidents are events that create significant risk of substantial harm to the physical or mental health of waiver participants. Critical incidents requiring a major level of review generally include

deaths, physical and sexual abuse or sexual assault, neglect, exploitation, suicide attempts, unscheduled hospital admissions, severe or moderate injuries, Level 3 medication errors and AWOL/Missing persons reports. Critical incidents requiring a minor level of review generally include verbal abuse, mistreatment, and property damage.

Procedures:

All agencies are required to notify ADMH of all reportable incidents and take action 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 certification 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: Psychological and Behavioral Services
Reference: ADMH Administrative Code 580-5-30-.02 (2), Behavioral Service Procedural Guidelines: DDD-PBS, HCBS Waivers
Effective: Historical Practice
Statement: The Behavioral Service Procedural Guidelines were established to provide behavioral services for individuals with intellectual disabilities in the state of Alabama. The guidelines were developed by the Behavior Analysis Task Force a group of professionals representing both community providers and the Developmental Disabilities Division of the Department of Mental Health. The guidelines were developed using the principles of Applied Behavior Analysis as the foundation. Behavioral services based upon these principles have resulted in successful skill acquisition and/or behavior reduction for 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.
HCBS Waivers: ID/LAH
Definitions: The Behavioral Guidelines describe all of the behavioral training and intervention strategies that are approved for use in the state of Alabama. The term behavioral refers to interventions that focus on actual, measurable, real-world behaviors and outcomes; HRC (Human Rights Committee); BPRC (Behavior Program Review Committee); IDT (Interdisciplinary Team); BSP (Behavior Support Plan)
Procedures:

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

6. Requests for training can be made through the three Comprehensive Support Teams, as well as through the Director of Psychological and Behavioral Services.

A.7.2 Behavior Support Plan Writing and Content

Responsible Office: Psychological and Behavioral Services

Reference: ADMH Administrative Code 580-5-30; Behavioral Services Procedural Guidelines: DDD-PBS, HCBS Waiver Manual

Effective: April 1, 2021

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

Definitions: *Behavior Support Plan*- also referred to as a BSP is a plan that assists an individual in building positive behaviors to replace or reduce challenging/dangerous behavior(s). Behavior- defined as any observable and measurable act of an individual, bad, or good. *Target behavior*- defined as the undesirable or maladaptive behavior to be changed. The target behavior should be defined in specific and objective terms. *Functional Behavior Assessment*- 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.

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. 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.
3. The BSP consists not only of the written plan but also its implementation.
4. There should be evidence of staff training and competence in carrying out the BSP.
5. 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.

6. 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.
7. CONTENT- The BSP must include:
    a. Demographic and operational information
        i. Name, date of birth, and age of the individual
        ii. Author(s) of the plan and supervising BCBA if applicable
        iii. Date of implementation of the plan
        iv. 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
        i. Define each behavior of concern in terms that can be recognized when they occur
        ii. 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.
        iii. 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.
        i. 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.
        ii. A description of the replacement goals for each targeted behavior.

iii. 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:
   i. Name of the procedure
   ii. Level of restriction
   iii. Justification for inclusion in the BSP
   iv. Brief description of previous and current efforts to fade restrictive interventions

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

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

m. Due process safeguards. Signatures of:
   - Individual served
   - Guardian (if applicable)
   - Plan author
   - BCBA supervising the Plan
   - BPRC review and approval
   - HRC Review and approval

A.7.3 Specialized Behavior Service Provider

Responsible Office: 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

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

Procedures:

1. To access the Specialized Behavior Service Provider IRBI 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 O.G. 4.2) and list "Specialized Behavior IRBI" on the Other line when indicating what services are being requested.
   b. All BSPs, PCP, 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. <u>Individual served must have specialized behavioral needs</u>- evidenced by:
      i. an initial screening by a Regional Psych and Behavioral Evaluator
      ii. 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:
      i. 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

QDDP can write the plan based on the assessment. However, the BCBA should review, approve, and sign off prior to review by the Behavior Program Review Committee (BPRC) and the Human Rights Committee (HRC).

ii. 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.

c. 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-DDD-Specialized-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.

A.7.4 Request for Action for Special Level of Staffing Restrictions

Responsible Office: Regional Community Services
Reference: ADMH/DD Operational Procedures
Effective: Historical Practice
Revised: November 19, 2021
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
Definitions: 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:

1. 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).
      i. Data on fading periods (if applicable)
      ii. 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)
      iii. 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
      iv. GER's related to behavioral issues and restraint (manual, mechanical, and chemical) per reportable incident definitions
   c. Interdisciplinary team meeting note reflecting:
      i. Review of necessity of continuing special level of staffing restriction
      ii. Rationale for continuing special level of staffing restriction, if continued
      iii. Review of the effectiveness of the BSP
      iv. Review of progress on alternatives to targeted behaviors justifying the use of

special level of staffing

v. 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:

a. Detail on other interventions including use of adaptive equipment that has been attempted
b. Detail of supports that are required due to medical status
c. Most recent physical/medical assessment
d. Documentation/data on incidences related to medical condition (if applicable)
e. Current Status (i.e., progression, regression, or no change)
f. 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: 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.

A.7.5 Comprehensive Support Systems (CSS) Teams

Responsible Office: Behavioral Services

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

Effective: Historical Practice

Revised: April 1, 2023

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

Definitions: Individuals eligible for services provided by CSS Teams:

Individuals 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 an individual experiencing psychiatric hospital admission, incarceration, or challenges to maintaining community living.

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 currently located in Decatur, Tuscaloosa, Montgomery, and Mobile, within ADMH-DDD Regional Community Services offices. The teams offer state-wide coverage.
4. Consultation Services Provided:
    a. **Training**- Staff, agency, support persons trainings 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:

  i. Persons with ID who are receiving HCBS Waiver program services and are exhibiting challenging behaviors with the potential to escalate into a near-term 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.

  ii. Those for whom medical, psychiatric, or dental services cannot be obtained in the community for a person otherwise eligible for services provided by CSS Teams

  iii. Those for whom current behavioral or medical/dental treatment strategies are not effective for a person otherwise eligible for services provided by CSS Teams

  iv. Persons who have numerous psychotropic medications or high doses prescribed

  v. 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,

  vi. Involvement with law enforcement due to challenging behaviors

5. 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 to be 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, contact information is listed here: https://mh.alabama.gov/division-of-developmental-disabilities/psychological-and-behavioral-services/ .

A.7.6 ID/DD Dual Diagnosis Crisis

A.7.6.a ADMH-DDD/ Bullock County Hospital Crisis Referral Procedures

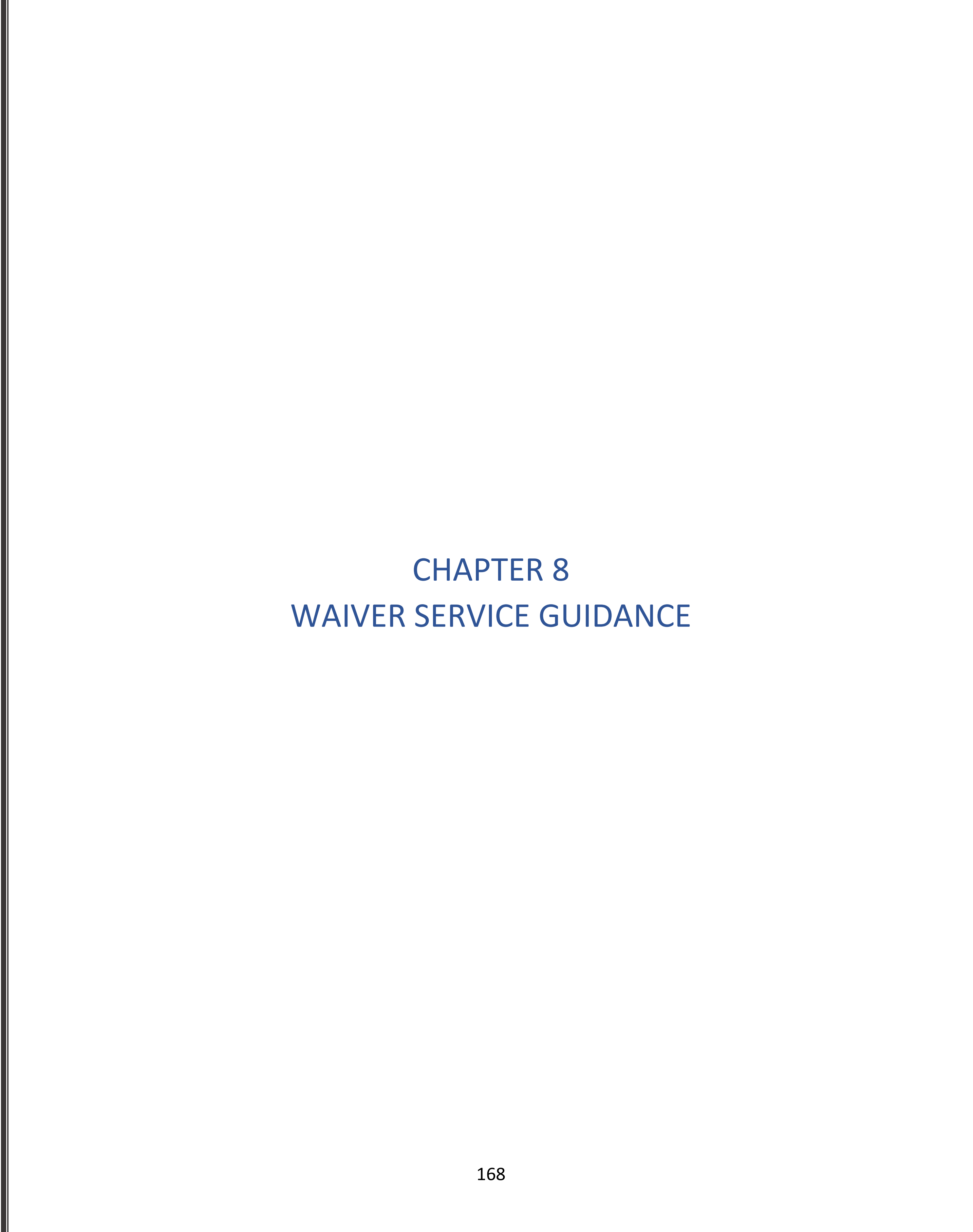
Responsible Office: Psychological and Behavioral Services
Effective: June 1, 2021
Statement: ADMH-DDD recognizes the need for increased resources relative to the service gap regarding mental/behavioral health crisis for individuals with intellectual and developmental disabilities statewide. A partnership between ADMH-DDD and Bullock County Hospital (located in Union Springs, AL) has been established to assist in addressing this need.
Purpose/Intent: Bullock County Hospital purposes to provide ADMH-DDD Crisis Care services through short-term acute inpatient psychiatric treatment and stabilization to individuals ages 19 and older. Referral and treatment processes are described in the following procedures.
Scope: DDD HCBS Waiver Service Providers; ADMH-DDD Central Regional Offices; Support Coordinator Services; Autism Services
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.
3. The individual should meet one or more of the following criteria to establish medical necessity for inpatient psychiatric care at Bullock County Hospital:
    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.
    f. The individual has experienced an acute onset of severe mental anguish to the extent that the individual cannot function outside of an inpatient setting.
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 prior to issuing an intent to discharge an individual from residential services (where applicable).
5. Provider/caregiver/representative will complete the Bullock County Hospital DD Crisis Intake Form (Pre-screening Evaluation) *(See List of Forms Table)* and contact their Regional

Community Services Director to make referral for inpatient crisis care. Any Behavior Support Plans and/or Psychotropic Medication Plans (where applicable) should be submitted with intake form.

6. 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.

*Note: Bullock County Hospital – ADMH-DDD Crisis Care – Pre-Screen Evaluation Form



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

Responsible Office: Administrative and Fiscal Operations

Reference: N/A

Effective: Historical Practice

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

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

HCBS Waivers: ID/LAH

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

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

A.8.1.b Absentee Rates

Responsible Office: Administrative and Fiscal Operations
Reference: N/A
Effective: Historical Practice
Statement: Calculation of Absentee Rates for the IRBI
Purpose/Intent: To establish eligible dates for calculating individual residential absentee rates.
HCBS Waivers: ID/LAH
Definitions: IRBI (individualized residential budgeting instrument)
Procedures: Providers are allowed to change existing residential absentee rates on the IRBI once a year in the month of August to be reflected on the authorizations beginning September 1st. Changes in absentee rates should be requested directly to the Fiscal Manager representing the region of the individual's residence.

A.8.1.c IRBI Completion and Workflow

Responsible Office: Administrative and Fiscal Operations
Reference: N/A
Effective: Historical Practice
Revised: May 7, 2021
Statement: Party responsible for completion of IRBI 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
Definitions: IRBI (individualized residential budgeting instrument); DMH (Department of Mental Health); RFA (request for regional action)
Procedures: Residential providers will bear the responsibility of completing IRBIs on individuals served in residential settings when the individual is placed with the program and when any changes are needed in the IRBI for staffing coverage (to be approved through the RFA process). The IRBI should reflect the individual's needs, as set forth in the person-centered plan. If help is needed with completing the IRBI, 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 and absentee rate from the provider. The provider will then complete the IRBI and send it to their Regional Community Services Director. The director will check the IRBI to ensure it aligns with the context of the person-centered plan.

When approved, the IRBI will be scanned into ADIDIS by regional office staff. Support Coordination will be added as a note recipient.

An updated IRBI is required from provider of residential services when any of the following occur:

1. Change in a person's address
2. Change in a person's daily schedule
3. Change in housemate status (change in housemate staffing needs, i.e., 1:1)
4. Change in status of housemate schedule
5. Change in ICAP score

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

The IRBI will be reviewed, in conjunction with an individual's Person-Centered Plan (PCP), by regional office staff before a site is monitored.

A.8.2 Provider Recoupment Guidelines

Responsible Office: Administrative and Fiscal Operations
Reference: Administrative Code 580-5-30(.03) 580-5-30-.05 and 580-5-30-.10; DDD IPMS Guidelines 6.4; ADMH Contract
Effective: November 1, 2020

When findings of DDD monitoring, certification reviews, audits, etc. reveal potential improper billings by providers, overpayment and/or unwarranted billings and payments for services, and/or misuse or theft of client funds, the DDD staff shall:

1. Central Office Directors will notify the DDD Associate Commissioner and provide all related documentation and evidence including written report of findings.
2. The DDD Associate Commissioner will review the findings and make a determination if further review and/or investigation are warranted.
3. If the Associate Commissioner determines there is no impropriety and that no further review or investigation is warranted, the Associate Commissioner shall inform the referring DDD staff and ensure that training, technical assistance, etc., as appropriate, is provided to address the findings.
4. If the DDD Associate Commissioner determines that further review and/or investigation is warranted, the Associate Commissioner will refer and request an investigation be conducted by the proper ADMH Officials including, Bureau of Special Investigations (BSI); ADMH Internal Advocacy Office, ADMH Internal Audit Office or other as deemed appropriate. If findings involve potential misuse of federal funds or non-ADMH state funds, such as Medicaid, Social Security, etc., the Associate Commissioner will notify the appropriate agency, provide copies of written findings and inform of referral, if any, to other ADMH Officials for review and investigation.

ADMH Officials including, Bureau of Special Investigations (BSI); ADMH Internal Advocacy Office, ADMH Internal Audit Office or other as deemed appropriate. If findings involve potential misuse of federal funds or non-ADMH state funds, such as Medicaid, Social Security, etc., the Associate Commissioner will notify the appropriate agency, provide copies of written findings, and inform of referral, if any, to other ADMH Officials for review and investigation.

A.8.3 Public Health Emergency

A.8.3.a Covid-19 Infectious Disease Emergency Plans for Direct Support Providers

Responsible Office: Administrative and Fiscal Operations
Effective: June 10, 2020
Statement: Direct Service providers must be prepared to serve individuals receiving Waiver services during an infectious disease emergency with the utmost accountability to meet the health and safety needs of individuals with Intellectual Disabilities, who are considered “vulnerable persons” by the CDC, due to higher potential for underlying conditions that may place them and the direct support staff who assist them at an increased health risk, particularly as related to COVID-19. Examples include those individuals 65 or older and/or with underlying medical conditions that may increase risk of serious COVID-19 include but are not limited to: Blood Disorders (e.g. sickle cell or on thinners), Chronic Kidney Disease (medication treatment or dialysis), Chronic Liver Disease (cirrhosis, chronic hepatitis), Compromised Immune System (immunosuppression) cancer, chemotherapy/radiation, organ or bone transplant, high doses of corticosteroids or immunosuppressant medication, HIV/AIDS. Endocrine Disorder (diabetes mellitus) Metabolic Disorder (inherited or mitochondrial disorder) Heart Disease (Congenital, congestive or coronary artery disease) Lung Disease (Asthma, chronic obstructive pulmonary disease, bronchitis, emphysema, impaired lung function, or required oxygen), Intellectual Disability, Neurological, neurologic and neurodevelopmental conditions (brain spinal cord disorders, spinal cord injury, peripheral nerve, cerebral palsy, epilepsy, seizures, stroke, moderate to severe developmental delay, muscular dystrophy).
Purpose/Intent: Direct Support agencies will compose and maintain written emergency plans, policies, and procedures to ensure they can successfully implement strategies to mitigate and respond to an outbreak of epidemic/pandemic proportions of an infectious disease (e.g., COVID-19).
HCBS Waivers: ID, LAH
Definitions: Division of Developmental Disabilities (DDD); Regional Community Services (RCS); Community Services Director (CSD); Support Coordination Entities (SCE’s); Incident Management & Prevention System (IPMS); Occupational Safety & Health Administration (OSHA); Centers for Disease Control (CDC)
Procedures:

1. All Direct Support Service agencies serving individuals receiving Waiver services must compose, maintain and implement an emergency plan for mitigating and responding to epidemic/pandemic outbreaks of infectious disease (e.g., COVID-19). This emergency plan must include, at a minimum, the following elements:
    a. Distinct phases of the Direct Support Service agency activity, dependent upon governmental/public health mandates (e.g., work from home, infection control, social distancing, quarantine, shelter in place, etc.).
    b. Specific changes to Direct Support Service agency operations in each phase, including:
        i. Methods to access necessary records and information for individuals receiving Waiver services by oversight and service coordination entities.
        ii. Methods for maintaining reliable and consistent communication between RCS, SCE’s, individuals receiving Waiver services, and families/caregivers.

iii. Methods for communicating emergency plans, and their level of implementation, to individuals receiving Waiver services, families/caregivers, SCEs, and RCS.

iv. Methods for communicating any changes in staffing ratios as a result of the infectious disease emergency occurring.

v. Methods for communicating with individuals receiving Waiver services, SCE's, RCS, and families/caregivers regarding, and acting expeditiously upon, the potential need for emergency services or emergency changes to existing services, should the person, provider, family, caregiver, or other critical supports become unavailable as a result of the infectious disease emergency occurring.

vi. Plan for effectively continuing operations if/when the Direct Support Service agency experiences reduced staffing capacity as a result of staff contraction of the infectious disease.

vii. Screening and Policies (including reporting of positive results and time frames for such) for Employees Exhibiting Signs and Symptoms per CDC guidelines.

viii. Screening and Policies (including reporting of positive results and time frames for such) for Persons Served Exhibiting Signs and Symptoms per CDC guidelines.

ix. Screening and Policies (including reporting of positive results and time frames for such) for anyone (e.g., Department Staff, members of the community, maintenance personnel) entering settings.

x. Notification of Exposure per ADMH directives through IPMS, and other reporting requests, and also in compliance with standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

xi. Full compliance with CDC guidelines relating to safe practices that reduce risk of exposure of the virus by individuals served, staff and family members at a minimum should include the following:

- ❖ Handwashing and sanitary practices per CDC guidelines to include respiratory etiquette (e.g., covering your cough or sneeze).
- ❖ Social distancing strategies, per CDC guidelines, to include the following:
    - o Physical environments will be adapted based on square footage and (per ADMH/APDH/CDC guidelines) limitations on group sizes in individual rooms throughout the Center;
    - o Measures to prevent cross contamination (e.g., no rotation of classes);
    - o In-person and large group meetings relating to service coordination and planning;
    - o Administrative function of the entity;
    - o Restrooms;
    - o Meal planning and communal dining; or
    - o Creating more space between work or training stations.

xii. Housekeeping (all settings) – sanitizing and disinfecting, at a minimum, tables, other surfaces, door handles, light switches, bathrooms, vehicles, technology, and equipment (e.g., computers, phones, etc.) and other common touch points

throughout the day, using a CDC-approved sanitizer/disinfectant and the frequency these tasks should be accomplish.

xiii. Transportation, public and private, to include social distancing requirements and sanitation practices per CDC guidelines will be accomplished.

xiv. Procedures for identifying and correcting non-compliance with health and safety procedures (e.g., refusal to wear mask during transportation).

xv. Provider requirements for signed assurance statements by and between the agency and individual/family.

xvi. Procurement, distribution and use of personal protective equipment, and the maintenance thereof, according to CDC and OSHA guidelines.

xvii. Managing employment outcomes for individuals served to include individual risk assessments and employer work environment.

xviii. Collaborative engagement with the person, family, support Team and led by the Support Coordinator, to complete an Individual Risk Assessments for participation in community activities, visitation with family, and day services, etc.

xix. Distinct communications and training plans to mitigate risk so to ensure best possible health and protections of individuals served, families, and staff, to include utilization of communications that best meets the needs and learning styles of individuals served.

2. As circumstances dictate shifting through the phases of the Infectious Disease Emergency Plan, the Direct Support Service agency is to report these changes to the SCE and RCS CSD(s) immediately as they occur.
3. The Infectious Disease Emergency Plan must be composed, updated, and implemented within thirty (30) days of the publication of this Operational Guideline, or as mandated by DDD if required during an infectious disease emergency (e.g., COVID-19). Upon completion, it is to be immediately submitted for review/approval to the Community Services Director(s) (CSD's) of the Region(s) in which the Direct Support agency operates.
4. The Infectious Disease Emergency Plan is to be reviewed and updated as new ADMH and/or ADPH/CDC guidelines are released during the pandemic and annually when there is no pandemic. The Infectious Disease Emergency Plan is subject to review by RCS and Certification staff individuals to ensure compliance.

A.8.3.b Covid-19 Appendix K - Temporary Presumed Eligibility During a State of Emergency

Responsible Office: Waiver Services
Reference: Covid-19 Appendix K
Effective: January 26, 2020
Statement: In times of emergency, individuals with intellectual disabilities may be especially vulnerable and in potentially greater need for services but without normal access to documentation/assessments to substantiate eligibility for Waiver services.
Purpose/Intent: When a State of Emergency is declared by the Federal, State, or Local government within whose jurisdiction Waiver services are being delivered, eligibility criteria for Waiver services may be relaxed to ensure timely access to services by individuals presumed eligible and in need.
HCBS Waivers: ID, LAH
Definitions: Division of Developmental Disabilities (DDD); Regional Community Services (RCS); Community Services Director (CSD)
Procedures:

1. Temporary Presumed Eligibility standards remain in effect until such time as the applicable State of Emergency is lifted.
2. During this period of time, Temporary Presumed Eligibility standards allow for the following practices during determination of eligibility;
    a. Remote eligibility activity – All eligibility activities (including applicant and clinician contact) may be completed remotely. Specifically, in-person activities (such as intakes and interviews) may be completed by phone, or secure telehealth technology, when possible to avoid in-person contact and limit risk of spreading the infectious disease. Additionally, please request all medical records, school records, and other required documentation electronically or by mail.
    b. Remote Telehealth – Support Coordinators conducting eligibility activities may accept evaluations from psychologists that were completed remotely. Telehealth evaluations with adaptive (or other, as applicable) assessments completed with telehealth technology (i.e., phone or secured video technology) should follow HIPAA requirements. In the event an in-person or telehealth evaluation or assessment is required by another policy or standard and cannot be completed, apply Presumed Eligibility protocols.
    c. Presumed Eligibility – In the event that an administrative evaluation is not possible, and substantiating documentation of all eligibility criteria (as per ADMH-DDD OG A.8.2) is not available, any of the following substantiated data will be accepted:
        i. Most recent IQ test with Full Scale Intelligence Quotients (IQ) scores less than 70, prior to age 18.
        ii. A qualifying Intellectual Disability (ID) diagnosis by a Qualified Professional without an adaptive assessment, prior to age 18.
        iii. When testing or documentation of a qualifying intellectual disability is unavailable, an attempt to obtain the attached Physician's Statement should be made to verify:
            - The Qualified Professional can affirm an ID diagnosis;

- The ID diagnosis directly causes an adaptive behavior impairment that significantly impacts Conceptual, Practical, Social functioning, or Socialization, Daily Living Skills, Communication areas; and
- The qualifying condition and impairment are reasonably expected to have occurred prior to the age of 18.

d. Presumed Eligibility Practices

i. Notes in the web-based application must clearly identify why Presumed Eligibility policy is used for an applicant.

ii. All notices of eligibility under Temporary Presumed Eligibility standards must indicate "Presumed Eligible" in the communication.

iii. The RCS Waiting List Coordinator must distinctly track Presumed Eligible cases and re-determine eligibility via standard means (as per ADMH-DDD OG A.8.2) within one (1) year of the Presumed Eligibility determination.

iv. A new decision notice must be sent to all individuals determined Presumed Eligible within ten (10) business days of that determination.

v. Re-determination must be completed prior to twelve (12) months from the initial Presumed Eligibility determination.

3. Whenever possible, ADMH-DDD OG A.8.2 should be followed if current documentation is available or telehealth technology will provide required eligibility documentation for the rule.
4. Eligibility determinations should be processed timely and not delayed unnecessarily. If the ADMH-DDD OG A.8.2 requirements are not met by current available records, the Waiting List Coordinator should implement Presumed Eligibility within 30 days of identifying a possible Presumed Eligibility case.

A.8.3.c Assistive Technology & Virtual Service Guidance via Appendix K/PHE2020

Responsible Office: Waiver Service Guidance
Reference: DDD HCBS Waivers
Effective: July 22, 2020
Revised: March 5, 2021
Statement: Assistive Technology and Virtual Services waivers per the COVID-19 Appendix K
Purpose/Intent: To provide guidance for accessing Assistive Technology and delivering virtual Services during the PHE/Appendix K waiver
HCBS Waivers: ID, LAH
Procedure:
Assistive Technology

1. Through the effective period of the Appendix K, verbal orders are allowed in lieu of prescriptions for Assistive Technology.
2. The recommendation for Assistive Technology must be documented in the PCP and must include the following:
    a. Who made the recommendation?
    b. Why the recommendation was requested/needed
        i. If a Service Coordinator identifies that assistive technology is needed to enable an individual to communicate with those outside their home or residence, they should complete the following steps:
        ii. Discuss with the individual and their team, as appropriate, if the addition of assistive technology would meet this need
        iii. If the individual agrees that the addition of assistive technology would meet this need, then,
        iv. the Support Coordinator <u>(SC) must work with the individual to identify and document the most cost-effective means of meeting this need in the Person-Centered Plan or Progress notes.</u>

            Examples include:
            - A webcam for individuals who already have adequate access to a computer or laptop that meets their needs.
            - A tablet or laptop with built-in camera for those without adequate access to appropriate technology that meets their needs.
        v. SC then adds the service to the POC/PCP documenting why the assistive technology is the most cost-effective option selected
            i. The SC must ensure there is a plan for the person to access connectivity (explore internet providers that may be offering free Wi-Fi or cellular internet access)
            ii. The SC should assist in the development of an agreement for use of Wi-Fi or internet if connectivity will occur utilizing the provider or family's system.
            iii. The SC must identify if there are risks associated with using assistive technology and if so, address the risks with the PCP Team by updating the Risk Management Plan.

iv. The SC must determine whether individuals need support to set up or use the technology and create a plan for this support in the PCP.
v. The SC must verify the agreed upon device was purchased and monitor the individual's progress towards the outcomes identified in the PCP.

Virtual Services

The Appendix K allows for an electronic method of service delivery (e.g., telephonic, virtual (like zoom), etc.). Services include Case management, Personal care that only requires verbal cueing, Day services, and monthly monitoring. Behavior Support Professionals, Nurses, and Occupational, Physical and Speech/Language Therapists may also provide electronic services in the home. Services should be documented in the person-centered plan and include why there is a need for electronic services (COVID-19) as opposed to the direct service that is traditionally provided.

NOTE: Virtual Services are intended to be used only in situations where in-person services are not advisable due to potential risk of exposure to COVID-19 and, therefore, should not be the first option for services.

A.8.4 Housing Specialist Access Request

Responsible Office: Regional Community Services
Effective: Historical Practice
Statement: A Housing Specialist is assigned to each Regional Community Services Office.
Purpose/Intent: The Housing Specialist assists individuals served on the Waiver with obtaining safe and adequate housing by guiding them through, and facilitating resolution of, the bureaucratic and financial processes involved.
HCBS Waivers: ID, LAH
Definitions: RFA (Request for Action); IDT (Interdisciplinary Team); PCP (Person-Centered-Planning)
Procedures:

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

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: Community Waiver Program
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
Definitions: 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:
    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:
        i. 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.

        ii. 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:
   i. 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.

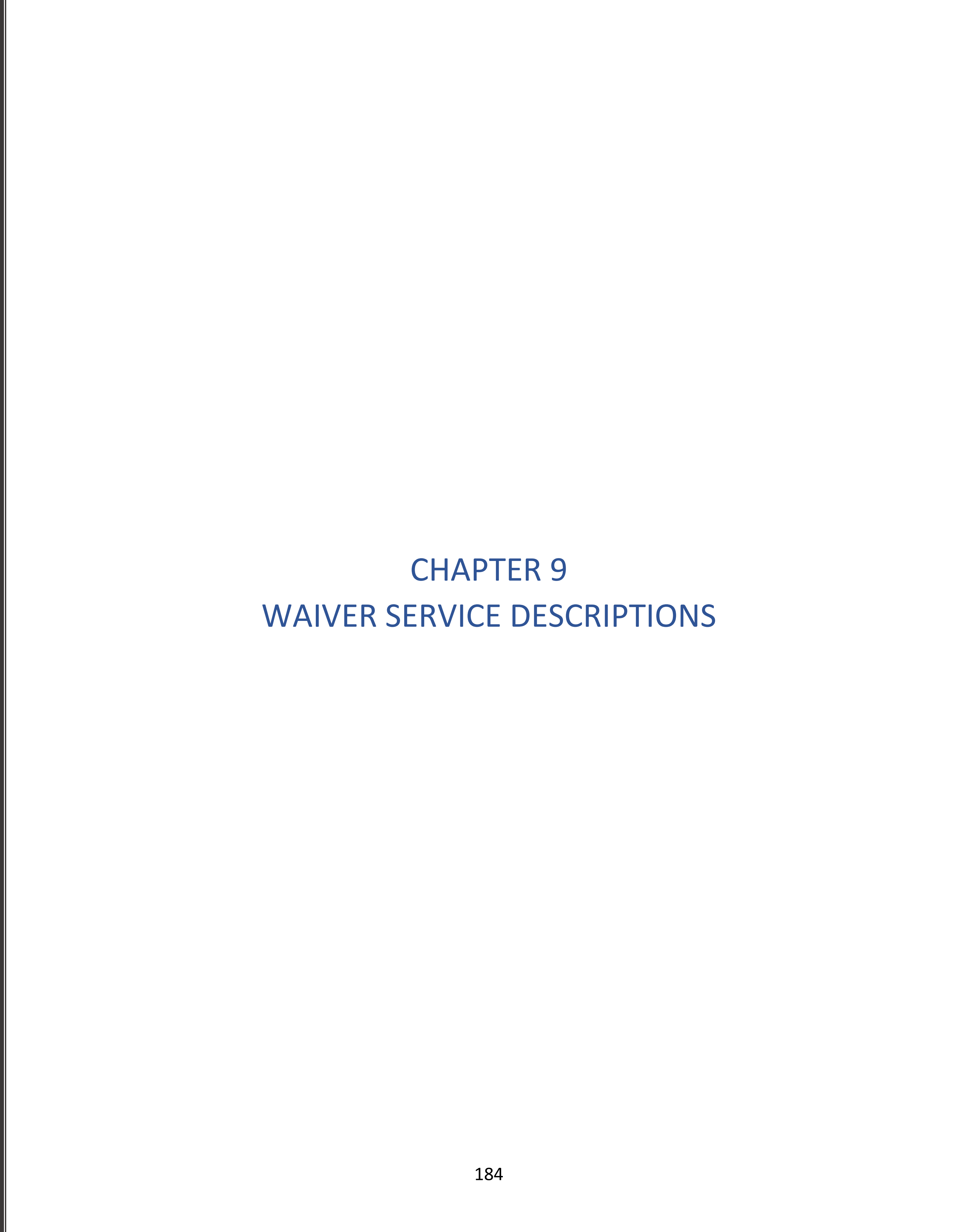
ii. Individual dose packets with tear-off seam similar to individual dose packets of over-the-counter drugs (E.g., Advil, Tylenol).

a. 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.

b. 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.

c. 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.

d. 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

Responsible Office: Office of Systems Management
Effective: December 20, 2020
Statement: ID and LAH Waiver Service information is published to the ADMH website as the ID and LAH Waiver Service Grid.
Purpose/Intent: ID and LAH waiver service information, to include service name, service code, service rate, service limitations, and service definition, is published to the ADMH website as centralized, concise information about ID and LAH waiver services.
HCBS Waivers: ID, LAH
Procedures:

1. The DDD Director of Systems Management:
   a. Updates the ID and LAH Waiver Service Grid as service rates change.
   b. Updates the ID and LAH Waiver Service Grid as services are added to the waiver.
   c. Updates the ID and LAH Waiver Service Grid as services are terminated from the waiver.
   d. Updates the ID and LAH Waiver Service Grid as waiver language relative to service definitions changes.
   e. Updates the ID and LAH Waiver Service Grid as waiver language relative to service limitations changes.
   f. Ensures the updated ID and LAH Waiver Service Grid is published to the ADMH website.
2. The ID and LAH Waiver Service Grid is published to the Division of Developmental Disabilities section of the ADMH website as ID and LAH Waiver Service Grid.
3. Information in the ID and LAH Waiver Service Grid provides a brief overview, rather than a complete recreation of waiver language. Complete waiver documents are also provided on the ADMH website for a more thorough review of waiver service details.

A.9.2 Supported Employment

A.9.2.a Discovery Assessment/Profile

Responsible Office: Office 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
Definitions: Discovery: A period of exploration to explore skills, interest, talents and abilities.
Procedures: A community-based assessment to develop a profile to pursue competitive employment. Discovery/Assessment is limited to no more than ninety (90) days and should not overlap other services and is available for individual participants interested in employment. The expectation is that much of the process be performed outside of a facility and off the grounds of the facility. The Discovery process should be individualized.

Discovery shall be limited to no more than 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: Office 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
Definitions: A generalized service that helps an individual progress down a defined pathway to employment. Only individuals interested in integrated and competitive employment should receive this service.
Procedures: The Prevocational habilitation service under the Waiver is designed to create a path to integrated, competitive employment in which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

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

Services are expected to occur within a period **not to exceed 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: Office 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) services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that: A generalized service that helps an individual progress down a defined pathway to employment. Only individuals interested in integrated and competitive integrated employment should be referred to VR.
Procedures: Vocational Rehabilitation Service (VRS), the largest division within the Alabama Department of Rehabilitation Services that assists Alabamians with disabilities achieve independence through employment.

VR provides specialized employment- and education-related services and training to assist teens and adults with disabilities in becoming employed.
The types of services available through VR are varied and designed specifically to meet the needs of each individual. Available through any of the 20 VRS offices statewide, services can include pre-employment services, transition services, educational services; vocational assessments and evaluations, guidance and counseling; job training; assistive technology; orientation and mobility training; and job placement and retention.

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

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

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

1. Once an individual expresses interest in working in competitive employment, an initial "Discovery" assessment should be provided. The Discovery process is an evidence-based alternative to comparative, standardized assessments, and evaluations completed by a qualified employment supervisor professional. Discovery is a person-centered planning process that

involves getting to know a person before supporting them in developing a plan for employment. (See Operational Guideline 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.
      i. Transportation options should be discussed so that once the employment goal is achieved, the individual encounters no difficulty getting to and from work.
      ii. 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).
      iii. Contact should be made with the local VR office and an appointment scheduled so individual can officially apply for VR services.
      iv. 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:
      i. 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).
      ii. Hire: The individual is placed into competitive employment and completes 3 days on the job.
      iii. Job Retention: The individual receives onsite job coaching to ensure that satisfactory job performance is achieved to maintain employment.
      iv. 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:
    i. Ongoing benefits planning and/or reporting services
    ii. Personal Care and/or Personal Care at the Worksite
    iii. Employment Transportation
    iv. 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: Office 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
Definitions: A distinct service that is utilized to help an individual obtain a job. This supported employment service is not available to recipients eligible for benefits under a program funded by either Section 110 of the Rehabilitation Act of 1973, or P.L. 94-142.
Procedures: When an individual expresses interest in obtaining a job, a referral should be made to the Alabama Department of Rehabilitation Services (VR). Once the referral is made to VR, the individual, along with the Support Coordinator and/or service provider should maintain contact with the VR Counselor to ensure follow through with eligibility determination. This VR eligibility determination should be made as soon as possible, but no later than 60 days from the initial application date. The individual is encouraged to provide a signed release to VR, so the VR Counselor can speak with the Service Coordinator and/or provider agency representative if necessary for additional information and/or monitor progress towards eligibility determination. Historically, VR has been hesitant to speak with anyone other than the individual due to HIPAA regulations.

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

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

This Job Developer service will be limited to 40 hours per year. An employment plan is required initially, and subsequent updates can request modifications to the above limitations based on the observations of the professionals involved and approved by the RO Employment Specialist/Coordinator.
Training Requirements: A job developer must complete an ADMH approved training curriculum. Examples of approved curriculums include the bi-annual Customized/Supported Employment training taught by consultants from Virginia Commonwealth University, or an approved web-based certification available through such entities as ACRE, Griffin Hammis, etc. Please contact the Office of Supported Employment with any questions related to approved certifications.

A.9.2.d.2 Job Coach

Responsible Office: Office 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
Definitions: A service that is utilized to teach job skills for competitive integrated employment and provide long term supports and follow up for job retention. This service if, furnished under the waiver, is not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.
Procedures: The job coach works directly with an individual that desires to work in competitive integrated employment. The minimal requirement for an individual providing the job coach service is graduation from high school or its equivalent and two years of work experience. A Bachelor's Degree with a major concentration in rehabilitation, industrial arts, vocational education, psychology or a related field is preferred. Work experience of a supervisory or training nature as well as knowledge of 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: Office 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
Definitions: Service that teaches job skills to a workgroup such as mobile work crews and other business-based workgroups employing small group of workers. The goal of this service is to develop skills that lead to individualized competitive employment in the community. This service is not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.
Procedures: Supported Employment Small Group must be provided in a manner that promotes integration into the workplace and interaction between participants and 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: Office 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
Definitions: Employment transportation is the provision of service to permit waiver participants access to and from their place of employment in the event the support team is unable to arrange alternate means of transportation to and from work. The provision of this service must be necessary to support the person in work related travel and cannot be reimbursed for merely transportation. This service is not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.
Procedures: Employment transportation is a distinct service to transport an individual to and from an integrated competitive employment setting. The team's efforts to secure transportation must be documented in the case record. This service shall not duplicate or replace the Medicaid non-emergency medical transportation program. This does not preclude other arrangements such as transportation by family or friends. It is the expectation that as part of the person-centered planning process and employment outcomes, long term transportation to and from the worksite will be facilitated and arranged.

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

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

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

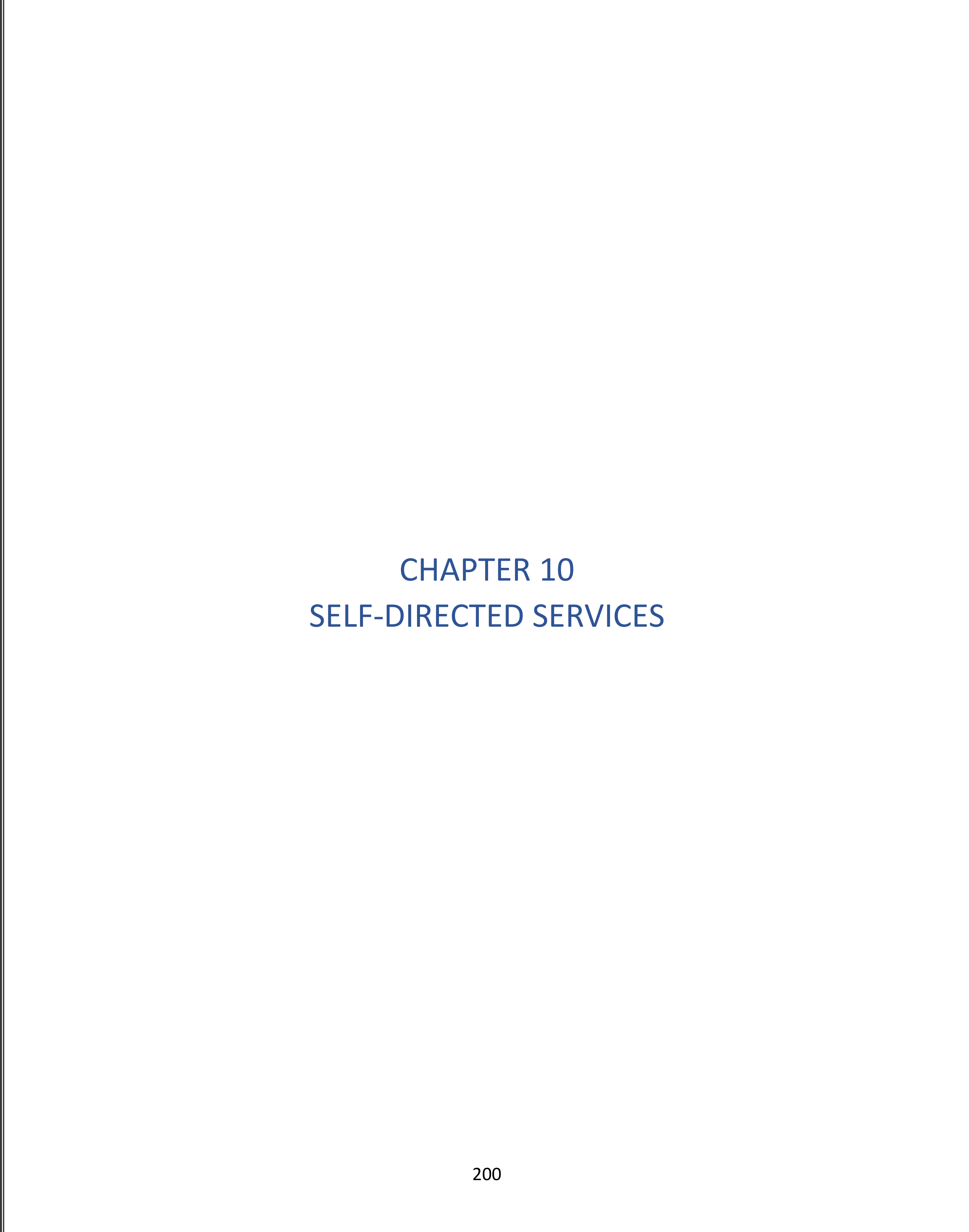
A.9.5 Benefits Planning and Reporting

Responsible Office: Office 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
Definitions: Benefits Planning and Reporting Services enable individuals to work while maintaining needed Social Security and medical benefits.
Procedures:
An individual wishing to pursue employment should be referred for benefits planning and reporting services. This can be provided either by an ADMH funded CWIC (Community Work Incentive Coordinator) 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 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: Self-Directed Services

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

A.10.2 Referral to Self-Directed Services

Responsible Office: Self-Directed Services
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
Definitions: SDS (Self-Directed Services) –A service delivery option; SDL (Self-Directed Liaison) –An individual who provided SDS application packet explanation of the procedures; RFA (Request for Action) – Additions to an individual's plan of care; ADIDIS (Alabama Developmental Intellectual Deficits Information System); FMSA (Financial Management System Agency) – Agency that provides payroll services to individuals who select SDS; EOR (Employer of Record) –Individual who will be responsible for oversight of SDS with in the home; EIN (Employer Identification Number)
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: Self-Directed Services

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

Definitions: Specialized Medical Equipment (SME), Specialized Medical Supplies (SMS), Environmental Accessibility Adaptations (EAA), Personal Emergency Response System (PERS)

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:

9. The Support Coordinator should review the person-centered plan and plan of care to ensure that the requested good or service is identified.
10. The Support Coordinator should review the monthly utilization report (budgetary savings report) to ascertain if the individual has the funds available for purchase.
11. 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.
12. 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

Responsible Office: Community Waiver Program

Reference: Microsoft Word - AUDIT GUIDE 2016.rtf (alabama.gov); Internal-Audit-Managers-Letter.pdf (alabama.gov); HCBS Rule Residential Setting-Specific Transition to Compliance Plan.xlsx (alabama.gov); HCBS Rule Non-Residential Setting-Specific Transition to Compliance Plan.xlsx (alabama.gov); Alabama ABLE; HCBS Settings Rule; Assessment Tool for Certification Reviews

Effective: March 10, 2022

Revised: June 7, 2022

Statement: The Alabama Department of Mental Health (ADMH), Division of Developmental Disabilities (DDD) has created a Provider Money Management Guide to improve financial wellness, cultivate financial accessibility and financial inclusion, and foster financial independence for individuals served with developmental and/or intellectual disabilities.

Purpose/Intent: Money management provision for individuals receiving waiver services must comply with Home and Community Based Services (HCBS) Settings Rule Standards in ensuring that all individuals served exercise their preferences in accessing and managing their own money, are trained in understanding basic money management principles, and are given options relative to available resources that benefit their overall financial wellbeing. Additionally, providers must ensure funding for services and supports for individuals are allocated, monitored, and tracked according to federal/state auditing and reporting guidelines, fiscal standards, and operational guidelines.

HCBS Waivers: CWP

Definitions: Home and Community Based Services (HCBS) - Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources

Procedures:

ADMH-DDD has developed the following money management indicators which serve as a guidance tool for providers and individuals served:

1. **Rights & Privileges**
   a. **Individual**
      i. Must be given the option to decide how to spend, save, keep, give away, invest, or direct their money
      ii. Must be provided the option to possess a checking or savings account, or other means to control his/her funds (i.e., debit card, refillable debit card, or personal checks, etc.)
      iii. Must be offered informed choices to control monetary resources
      iv. Must be offered training in utilizing their own money
      v. Offer to assist individuals served with money management (individualized budget) of their funds
      vi. Ensure timely/prompt access of monetary funds as requested by individuals served
      vii. Ensure that individual needs are met and sustained
      viii. Provide training to individuals served on how to access and manage their money
      ix. Optimize individuals served independence in accessing and using money
      x. Ensure individual preferences are supported and rights are protected
      xi. Ensure services and supports are self-directed

   b. **Provider**
      i. Offer to assist individuals served with money management (individualized budget) of their

funds

ii. Ensure timely/prompt access of monetary funds as requested by individuals served
iii. Ensure that individual needs are met and sustained
iv. Provide training to individuals served on how to access and manage their money
v. Any modifications of conditions of HCBS must be supported by a specific assessed need and justified in the PCP

c. **Outcomes**
   i. Optimize individuals served independence in accessing and using money
   ii. Ensure individual preferences are supported and rights are protected
   iii. Ensure services and supports are self-directed

2. **Access to Money**
   a. **Individual**
      i. Must be able to access funds at will
      ii. Provided the option to manage his/her own personal funds
   b. **Provider**
      i. Maintain a separate account for individuals served
      ii. Provide individuals served monthly reports of expenditures
      iii. Offer individuals served the option to create an Able Savings Plan to store monies with a maximum allowable balance of $100,000
      iv. Ensure that available funds on-site (petty cash) do not exceed $300 per individual
      v. Provide an assessment tool to help manage funds for individuals served who choose not to manage their own funds
   c. **Outcome**
      i. Promote financial independence for individuals served
      ii. Ensure individuals served spend their money in a manner reflecting their personal choices/preferences

3. **Financial Accountability**
   a. **Individual**
      i. Must be provided monthly financial statements to see how individual funds are utilized
      ii. Must be given the option to participate in the monthly, individualized budget process
      iii. Must be assured by the provider agency that their monies are kept safe and protected from fraud or misuse
   b. **Provider**
      i. Implement a check and balance system to include monthly review of individualized financial statements or expenditure reports with designated staff
      ii. Offer monthly meetings with individuals served to discuss individual budgets and expenditures (i.e., picture board or graphics)
      iii. Implement an internal, electronic financial monitoring and tracking system for individual budget expenditures (i.e., Quicken or a Microsoft Excel spreadsheet)
      iv. Hire or seek consultation from a financial expert or certified accountant
   c. **Outcome**
      i. Minimize risks of budgetary inconsistencies, fraud, or improper documentation/use of federal/state funds
      ii. Allow for financial maintenance/sustainability in the event of auditing or staff changes
      iii. Engage individuals served in seeing how their monies are disbursed according to their preferences

4. **Auditing**
    a. **Individual**
        i. Must be made aware that individual funds will be subject to auditing and reporting
    b. **Provider**
        i. Maintain a filing system of receipts (can be scanned copies electronically for additional safekeeping)
        ii. Required compliance audits are performed according to provider entity type (See Additional Resources)
        iii. Maintain fiscal records for a minimum of 3 years
    c. **Outcome**
        i. Ensure fiscal integrity
        ii. Ensure all financial transactions/recordkeeping have been properly documented in accordance with state/federal mandates
        iii. Validate individual services/supports costs

LIST OF FORMS TABLE FOR ID/LAH WAIVERS

Form Reference	Form Title
Operational Guideline A.1.1	*Initial Contact Information Form*
Operational Guideline A.1.6. e.	*ADMH Request for Placement & Instructions*
Operational Guideline A.2.1	*Notice of Appeal Rights Adverse Action*
Operational Guideline A.4.2	*Request for Regional Action & Instructions*
Operational Guideline A.4.3	*Annual Physical Examination Form*
Operational Guideline A.4.9	*Freedom of Choice Form*
Operational Guideline A.4.5	*Individual Experience Assessment Survey (IEA)*
Operational Guideline A.4.8 & A.5.10	*Annual Financial Assessment*
Operational Guideline A.4.8 & A.5.10	*Annual Functional Assessment*
Operational Guideline A.4.8 & A.5.10	*Rights Assessment – Everyone Has Human Rights and Responsibilities*
Operational Guideline A.4.8 & A.5.10	*Annual Safety Assessment*
Operational Guideline A.5.1	*Application and Setting Review Form*
Operational Guideline A.5.10	*PCP Timeline*
Operational Guideline A.5.11	*Rent Residency Agreement Guidelines*
Operational Guideline A.6.1	*Factors and Indicators Chart*
Operational Guideline A.7.6	*Bullock County Hospital, ADMH-DDD Crisis Care, Pre-Screen Evaluation*
Operational Guideline A.10.4	*Provider Money Management Guidance*

ADMH-Division of Developmental Disabilities **Call Center**	**INITIAL CONTACT INFORMATION FORM**
Caller Information	**Applicant Information**
Name of Caller:	Applicant Name (if different from Caller):
Relationship to applicant: ☐ Self (applicant) ☐ Legal Guardian ☐ Family (not Legal Guardian, describe) ☐ Other	Date of Birth: / Age: / Gender: ☐ Female ☐ Male SS#: Medicaid#:
Street/Box Address City/State/Zip	Street/Box Address City/State/Zip
County:	**County:**
Home Phone #: Work #: Cell #:	Home Phone #: Work #: Cell #:
Email address:	Email address:
Military Affiliation Active (of whom? Caller or person being referred?): ☐Yes ☐No Whom: Best Contact Time: A.M. P.M. Anytime	**Our Vision: A continuum of care focusing on…** Keeping families together Supporting productivity and Community Inclusion Reaching those in need **ADMH-DDD Staff are "MAKING A DIFFERENCE"**

Reported Diagnosis:

Intellectual Functioning:

Medical Conditions (e.g., seizures; constipation; heart issues; incontinence; other):

Impairments (e.g., Physical; Vision, Mobility, Hearing):

Residence Type:

Does the person lease/rent or own their own home? ☐ Lease/Rent ☐ Co-Lease/Rent ☐ Own ☐ Co-Own

Which of the following best describes current residence of applicant?

☐ Lives in home owned by self ☐ Lives in home owned by family member(s) ☐ Lives in home leased/rented by self
☐ Lives in home leased/rented by family member(s)
☐ Lives in home co-leased/rented with others (specify how many others and relationship to applicant)
☐ Lives in home co-owned with others (specify how many others and relationship to applicant)
☐ Lives in home owned by a paid service provider (if yes select one from the following):
☐ Facility 16+ residents ☐ Group Home (7-15 residents) ☐ Group Home (1-6 residents)
☐ Youth Foster Home ☐ Adult Host Home ☐ Other (specify):
☐ Homeless (specify shelter; on street; in car; other):
☐ Other (describe):

Income:
Employment: ☐Yes ☐No Employer: Avg Hours/Week: Avg Income/Week:
Other Income Source(s):
☐SSI $ per month ☐SSDI $ per month ☐Other $ per month

Briefly describe current situation:

Other Assistance Programs and Community Resources that have been tried:

Legal Guardian (if applicable): ☐ Self ☐ Parent ☐ DHR ☐other
Note: For information only, is legal action being taken through the court system for someone to be declared the legal guardian? ***Explain clearly this is *not* required for the applicant to be found eligible for DDD Medicaid Waiver services.***

Name of person seeking to be named legal guardian:
Street Address:
City: State: Zip Code:
Phone: Home ( ) Work ( ) Other ( )

Additional Comments:

Type of Referral
Update of Existing Application (to 310 Board Intake Agency) ☐ **Yes** ☐ **No**
Initial Application Referral
☐ County of Residence in Community Waiver Program Pilot Area (Refer to RCS Waiting List Coordinator and corresponding 310 Board Intake Agency)
☐ County of Residence outside Community Waiver Program Pilot Area (Refer to RCS Waiting List Coordinator and Corresponding 310 Board Intake Agency)
Emergency Referral: ☐ DHR ☐ Dept of Education ☐ Court ☐ Hospital (Acute, Psych, other) ☐ DDD Autism Svc
Info/Referral Only (Describe):

Action Taken (to include name of agency the caller/applicant is referred to and why):

Checklist:
Date of Referral: Completed by:
Individual Opened in ADIDIS? ☐ Yes ☐ No If yes, enter ADIDIS Case Number:
Contact Information added to ADIDIS Record? ☐ Yes ☐ No
ADIDIS Enrollment Record completed for 310 Board Intake Agency? ☐ Yes ☐ No
Application uploaded into ADIDIS? ☐Yes ☐ No Date, if other than Date of Referral:
Which 310 Board Intake Agency? Which Region?
Referral to DHR: ☐ Yes ☐ No Date
Date, if other than Date of Referral:
Letter ☐ Yes ☐ No **Brochure** ☐ Yes ☐ No Community of Practice packet ☐ Yes ☐ No

ADMH Request for Placement

Date of RFP:	Region of origination:	ADIDIS #:

What specific supports and services have been identified to best meet the individual's needs, goals and diagnosis?

The provider that would best support this individual to achieve community integration has the following resources available

More about the Individual seeking supports and services ...

Gender:	Age:	Legal Status (check all that apply)			
		Guardian	Court ordered to ADMH	Alabama Medicaid Authorized Representative:	Other:

What, if any, are the Medical supports needed to ensure optimum Health and Wellness and community integration?

What, if any, are the Behavioral and Mental Health supports needed to ensure successful community integration?

What, if any, are the Physical supports needed to ensure successful community integration

What are the supports needed to achieve successful independent living?

What are the supports needed to achieve successful employment?

What are areas of interest unique to this individual, or things important to, that should be explored or be supported to achieve successful placement?

If your agency has the capacity (trained staff, transportation, etc.) that would support this individual to achieve successful community integration and would like to support them in any or all support/service areas above, please return this form to the person indicated below indicating your interest.

Authorized Agency Signature/Date:	Areas of interest:

With the individual or their legal representative's consent, if provider indicates interest as stated above, additional information may be shared. Documents 'may' include the following: (Example: Person Centered Plan, Social History, Behavior Support Plan, Psychotropic Medication Plan, Physical/Medical Assessment, and at minimum, the last three Quarterly Narratives) Please indicate documents for review below:

Replies to this RFP should be submitted to the individual below:	No Later Than (Date)

INSTRUCTIONS - ADMH Request for Placement

Date of RFP: Date RFP Released	Region of origination:	ADIDIS#:

What specific supports and services have been identified to best meet the individual's needs, goals and diagnosis?

The provider that would best support this individual to achieve community integration has the following resources available (Response should be specific to the individual; Examples may include but are not limited to: transportation to work, employment services, staff with specific training - CPI/MAB, access to BCBA, access to mental health services, transportation/supports to participation community activities):

More about the individual seeking supports and services.....

Gender:	Age:	Legal Status (check all that apply)			
		Guardian	Court ordered to ADMH	Alabama Medicaid Authorized Representative:	Other:

What, if any, are the Medical supports needed to ensure optimum Health and Wellness and community integration? (Response should be specific to the individual; Examples may include but are not limited to: dietary needs, working out at the gym, medication supports, support to dialysis or cancer treatments)

What, if any, are the Behavioral and Mental Health supports needed to ensure successful community integration? (Response should be specific to the individual; Examples may include but are not limited to: needs a structured, step by step instruction with few demands at one time, respectful verbal prompts, sensitive to sensory needs; needs supports by Staff who have completed the Enhanced Behavioral provider training)

What, if any, are the Physical supports needed to ensure successful community integration? (Response should be specific to the individual; Examples may include but are not limited to: vision - specific eyewear, adaptive aides; hearing - emergency lighting that flashes during a fire, sign language, someone familiar with communication board; mobility-ADA accommodations, communication - picture board)

What are the supports needed to achieve successful independent living? (Response should be specific to the individual; Examples may include but are not limited to: Assistive Technology would meet support needs overnight, transportation to the community, an apartment within walking distance of shopping, employment, church)

What are the supports needed to achieve successful employment? (Response should be specific to the individual; Examples may include but are not limited to: Transportation in the afternoon to work 1-5 shift, discovery waiver service to learn what types of employment would be successful)

What are areas of interest unique to this individual, or things important to, that should be explored or be supported to achieve successful placement?

(Response should be specific to the individual; Example: JP enjoys yoga to decrease anxiety, SB walks when she is anxious, space to walk, going to church is important as VM loves to work with children in the day care, LM having his own Lawn mower cut grass will not only allow him to make money, but connect with members in the community)

If your agency has the capacity (trained staff, transportation, etc.) to provide some or all support/service areas described above, please return this form to the person indicated below indicating your interest.

Authorized Agency Signature/Date:	Areas of interest:

With the individual or their legal representative's consent and if provider indicates interest as stated above, additional information may be shared. Documents 'may' include the following: (Example: Person Centered Plan, Social History, Behavior Support Plan, Psychotropic Medication Plan, Physical/Medical Assessment, and at minimum, the last three Quarterly Narratives) Please indicate documents for review below:

Replies to this RFP should be submitted to the individual below:	No Later Than (Date)

KAY IVEY
GOVERNOR

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

KIMBERLY G.BOSWELL
COMMISSIONER

NOTICE OF APPEAL RIGHTS ADVERSE ACTION

If an individual/guardian chooses to appeal an adverse action with regard to services provided through Medicaid Home and Community-Based Services Waiver programs administered by ADMH Division of Developmental Disabilities (ADMH-DDD), they may choose to appeal through an informal conference to the ADMH-DDD. If you are not satisfied with the decision rendered, you may request a fair hearing to the Alabama Medicaid Agency.

REQUEST AN APPEAL/INFORMAL CONFERENCE TO THE ALABAMA DEPARTMENT OF MENTAL HEALTH

To appeal to the ADMH Division of Developmental Disabilities. A written request for an appeal through an informal conference must be received in the Office of Appeals and Constituent Affairs no later than 15 calendar days after the effective date printed on the Notice of Action. Once ADMH-DDD is in receipt of the request for appeal and the review procedures are followed, a written decision from the Associate Commissioner will be mailed to the individual/guardian within 21 days after the review of all information. Send written requests for an appeal through an informal conference to:

ADMH-Division of Developmental Disabilities
P.O. Box 301410
Montgomery, AL 36130-1410

REQUEST A FAIR HEARING TO THE ALABAMA MEDICAID AGENCY

If the individual/guardian disagrees with the Associate Commissioner's decision, he/she can request a Fair Hearing to the Alabama Medicaid Agency. A written hearing request must be received by Medicaid no later than 60 calendar days from the date of the Associate Commissioner's letter.

The individual, legally appointed representative, or other authorized person must request the hearing and give a correct mailing address. If the request for a hearing is made by someone other than the person who wishes to appeal, the representative must make a definite statement that they have been authorized to do so by the persons for whom the hearing is being requested. Information about hearings will be forwarded. Plans will be made for the hearing and a date and place convenient to the persons involved will be arranged. If the individual is satisfied before the hearing and wants to withdraw their request, either the individual, their legally appointed representative, or other authorized person should write the Alabama Medicaid Agency that they wish to do so and give the reason for withdrawing.

Send written request for a fair hearing to:

ALABAMA MEDICAID AGENCY
LTC Healthcare Reform Division
P.O. Box 5624, 501 Dexter Avenue Montgomery, AL 36103-5624

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

Signature of Recipient or Legal Representative	Date
Print Recipient's Name	Witness Signature and Date

ALABAMA DEPARTMENT OF MENTAL HEALTH

DIVISION OF DEVELOPMENTAL DISABILITIES

REQUEST FOR ACTION (RFA)

DATE______________________________

TO: RCS DIRECTOR/DESIGNEE_________________________________

FROM: SUPPORT COORDINATOR_____________________________________ AGENCY: ________________________

WAIVER PARTICIPANT INFORMATION

NAME: ____ CASE NUMBER: _________________________________

ADDRESS (street, city, zip, Apt.): ____

PROVIDER AGENCY: ____

WAIVER TYPE: ☐ ID ☐ LAH

SERVICE REQUESTED

☐ SERVICES NOT CURRENTLY AUTHORIZED ON PLAN OF CARE

Service: ____

☐ SPECIALIZED STAFFING

☐ CSST CONSULTATION

☐ SELF-DIRECTED SERVICES REFERRAL

☐ OTHER: ____

REQUEST

☐ APPROVED ☐ DENIED ☐ INCOMPLETE

REGIONAL OFFICE COMMENTS:

____ __________________________________

RCS DIRECTOR/DESIGNEE DATE

Please use for additional information

ALABAMA DEPARTMENT OF MENTAL HEALTH DIVISION OF DEVELOPMENTAL DISABILITIES REQUEST FOR REGIONAL ACTION (RFA) INSTRUCTIONS

A team meeting is required prior to submission of the RFA. This form should be completed after appropriate members of the team have met.

1. Type in the date the RFA is complete
2. Type in the name of the Regional Community Services Director or Designee
3. Type in your name and 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 (of individual)
- Indicate Waiver Type

S. Service Requested:

- Check the service that is being requested:
- Services not currently authorized on the Plan of Care - indicate the specific service name
- Specialized Staffing
- CSST Consultation
- Self- Directed Services - indicate the specific service(s)

6. Request:

The Support Coordinator will complete this box. Justification for the addition of the service is required. Documentation should be brief and concise and fully note the participant's need for the service. Request should include but is not limited to service name, the need of service(brief/concise), the units/frequency of service, and the provider of the service.

ADIDIS Recipient(s) to Tag	RO RFA Account	RO Evaluator	ROWL Coordinator	RO Waiver Coordinator	SDS Liaison
Requests for Regional Action	X				
SLS Requests		X			
CSST Referral		X			
PBS RFA's		X			
Self-Directed Services	X				X
Re-Determinations				X	
Waiting List Applications			X		

Waiver Services are not an entitlement but are necessary to support the participant in the community based on assessed need. Waiver services are not designed to benefit anyone other than the participant.

7. Regional Office Comments:

The RCS Director or Designee will complete this box.

The RCS Director or Designee will indicate if the request is Approved, Denied, or Incomplete.

- Approved: service(s) approved will be indicated in the box.
- 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
- Incomplete: there is not enough supporting documentation to decide about the requested service(s)

The RFA will be signed by the Regional CSD or Designee with the date the decision was determined.

ANNUAL PHYSICAL EXAMINATION FORM

Date of Exam: ____

A. General Information

Patient ____ DOB_________________

Ht ____________ Wt ____________ Temp ___________ BP ______________________

Sex: ☐Male ☐Female

B. Diagnosis/ Significant Health Conditions

Health/ Medical ____
Cognitive ____
Psychiatric ____
Other ____

C. Immunization/ Communicable Disease

Date of last Tetanus/Diphtheria: _______________________

Date of last Tuberculosis (TB) Screening: ________________ Results: _________________

Chest x-ray (date): _____________________ Results: ____________________________

Influenza (Flu): ________________________ Other:*(specify)* ______________________

Is the person free of communicable diseases? ☐Yes ☐No

If "No", describe ____

D. History of Hospitalization, surgery, and major medical issues during the past year

____

____

E. Physical Examination

Area	Typical	Atypical	Comments
HEENT			
Respiratory			
Cardiovascular			
Incontinence			
Genito-Urinary			
Abdominal			
Skeletal			
Skin			
Extremities			
Mental Status			

F. Laboratory Data

Type	Date	Results
Urinalysis		
HGB/HCT		
Cholesterol Test		
Glucose Test		
PAP Smear		
Mammogram		
Prostate Specific Antigen		
Other		

G. Medications

Name and Dosage	Schedule	Route	Purpose

H. Food Service and Dietary

Recommended diet and special instructions: ____

I. Adaptive or assistive equipment needs

☐N/A ☐ Wheelchair ☐ Walker

☐Other (please specify): ____

J. Limitation on activities or training

____

____

K. Treatment plan/ follow-up

____

____

L. Additional Comments

____

____

____

Physician's Name ____

Address ____

City, State, Zip ____

Telephone ____

____ ____________________

Physician's Signature Date

Intellectual Disabilities (ID) and Living at Home (LAH) Waiver Freedom of Choice:
To Be Completed by the Person and/or Legal Guardian/Appointed Representative with Assistance from The Support Coordinator

Participant Name: ______________________________ **Date:** ______________

The checkboxes and signature on this form attests that the person and/or the legal guardian/appointed representative[1] has: (1) received an explanation of the available Alabama Medicaid Home and Community-Based Services (HCBS) waiver for persons with intellectual disabilities, including information on the option to self-direct waiver services and/or choose a provider from the list of enrolled HCBS waiver-credentialed service providers; (2) agreed to the waiver applicant's responsibilities; and (3) received an explanation that the HCBS waiver is offered as an alternative to the choice of an institutional Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID) placement.

I. HCBS Waiver Services Available

A. ☐ I have received information on services available in the Waiver Program (ID or LAH) which is the Home and Community-Based Services (HCBS) waiver available to me.

B. ☐ I understand I have the right to receive the services in my Person-Centered Plan (PCP) in settings that are non-disability specific (not designed specifically for people with disabilities) and I understand that during the Person-Centered Planning process, I will be offered the choice to receive each of my services in settings not designed specifically for people with disabilities.

II. Option to Self-Direct Services and/or Choose Certified Service Providers if Enrolled in HCBS Waiver

A. ☐ I have received an explanation of waiver services that can be self-directed and how self-direction works.

B. ☐ I understand I have the option to self-direct some or all of the services in my Person-Centered Plan (PCP) that can be self-directed, or I can choose from available, credentialed service provider agencies.

III. Choice to Receive HCBS Waiver (Please Check Only One)

☐ I understand that enrollment in a Home and Community-Based Services (HCBS) waiver is strictly voluntary.

CHOOSE ONLY ONE:

1. ☐ At this time, I choose to receive Home and Community-Based Services (HCBS) by enrolling in the waiver.

2. ☐ At this time, I do not choose to receive Home and Community-Based Services (HCBS). I understand that I have a choice to select waiver services at a future point if I am determined eligible as long as the waiver is not at full capacity.

IV. Applicant's Responsibilities if HCBS Waiver is Selected

A. ☐ I understand the Home and Community-Based (HCBS) waiver will deliver services according to my Person-Centered Plan (PCP). I will cooperate in annual reassessment when my PCP is due for redetermination or when my life circumstances change.

B. ☐ I understand that my Person- Centered Plan (PCP) will be monitored and reviewed by my Support Coordinator, and I agree to participate in necessary meetings and interviews with my Support Coordinator when requested. I understand I can contact my Support Coordinator at any time I have questions about my PCP or the services that I receive.

V. Freedom of Choice and Notice of Fair Hearing (explanation of rights under 42 CFR Part 431, Subpart E)

A. ☐ I elect to participate in the Community Waiver Program (CWP) and receive Home and Community-Based Services (HCBS) as an alternative to placement in an institutional (ICF/IID). I understand that I may withdraw from the Community Waiver Program (CWP) at any time and that my participation in the CWP will not restrict my access to ICF/IID placement in the future.

B. ☐ I understand that if I am not allowed to make my own decision about whether to use institutional (ICF/IID) or Home and Community-Based Services (HCBS) waiver services, I can request a Fair Hearing and the Support Coordinator may assist with that process.

VI. Freedom of Choice Signatures

______________________________ ______________

Participant: Date:

______________________________ ______________

Legal Guardian/ Appointed Representative: Date:

______________________________ ______________

Support Coordinator Signature: Date:

Freedom of Choice Complaint/Grievance and Fair Hearing Process

As a person opting to enroll in a Home and Community-Based Services (HCBS) Waiver, you also have the right to request institutional services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). If you feel you have not been allowed to make your own decision about whether to use institutional (ICF/IID) or HCBS Waiver services, you have the right to file a formal complaint/grievance verbally or in writing, to have your complaint/grievance thoroughly and adequately investigated, and to request a Fair Hearing to have resolution brought to your complaint/grievance through adequate due process. The following agencies are available to investigate your complaint/grievance and respond to your request for a Fair Hearing.

Region I Community Services, Decatur, AL	(256) 898-2789
Region II Community Services, Tuscaloosa, AL	(205) 554-4302
Region III Community Services, Mobile, AL	(251) 283-6200
Region IV Community Services, Wetumpka, AL	(334) 676-5565
Region V Community Services, Birmingham, AL	(205) 916-7800
ADMH Division of Intellectual Disabilities	(334) 242-3701

ADMH Office of Advocacy Services	1-800-367-0955
Alabama Disabilities Advocacy Program (ADAP)	1-800-826-1675

It is suggested that you file your complaint/grievance with your local Regional Community Services Office first. However, you may choose to go directly to the Division of Developmental Disabilities, Office of Advocacy Services, ADAP, or call them at any time during the complaint/ grievance process if you are not satisfied.

ADMH – Division of Developmental Disabilities	**Medicaid HCBS Settings Rule Ongoing Monitoring Individual Experience Assessment Survey (IEA)**

Section A: General Information - A response to each question is required unless otherwise indicated.

1. Person's First and Last Name:	Date of Survey:
2. Does the person have a legal guardian? **If no, skip to question 4. If yes, answer 3a – 3c** A guardian is a qualified person appointed by a court to act for an incapacitated person only to the extent necessitated by the incapacitated person's mental and adaptive limitations or other conditions warranting the court-appointment of a guardian.	☐ Yes ☐ No
3. If yes, is the guardian a paid/corporate guardian (i.e., the guardian is an attorney or works for an agency), or an unpaid family/friend?	☐ Paid Guardian ☐ Unpaid Guardian
a. If Unpaid Guardian, enter the name of the Guardian	
b. If Paid Guardian, Enter the name of the Guardian/Agency	
c. Does the person live with the legal guardian? ☐ Yes ☐ No	
4. In which Waiver is person enrolled (select one): ☐ CWP Waiver ☐ ID Waiver ☐ LAH Waiver	
5. Name of Support Coordinator Conducting IEA:	
Support Coordinator employed by:	
Number of months SC has supported person:	6. Region (circle one): 1 2 3 4 5
7. If the person is not able to answer one or more of the questions independently, is someone other than the person responding? If **NO** skip to Section B If **YES,** answer 7a – 7b	☐ Yes ☐ No
7a. If yes, what is the First and Last name of the person assisting with responses?	
7b. What is his/her relationship to the person?	☐Child ☐Spouse/Partner ☐ (Other)Family ☐Friend ☐DSP ☐Guardian

****IMPORTANT: The person should always be asked first and the person's responses should always be used first.****

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

Question:	Response:	HCBS Setting Requirement:
1.Do you have your own bank account?	☐ Yes ☐ No	*Allows person to control personal resources.*
2.Do you have access to your money?	☐ Yes ☐ No	
3.Can you buy the things you need?	☐ Yes ☐ No	
4.Did someone tell you about the services and supports that you are eligible for?	☐ Yes ☐ No	*Facilitates personal choice regarding services and supports and who provides them.*
5.Did you choose the services and supports you are receiving from the list of services you are eligible for?	☐ Yes ☐ No	
6.If you have services in your person-centered plan that can be self-directed, were you given the option to choose between using self-direction and using a provider agency?	☐ Yes ☐ No ☐ N/A	
7. If you chose an agency provider for some of your services, were you given a choice of provider agency?	☐ Yes ☐ No ☐ N/A	
7.Did you choose the specific person/people who provide your services and supports?	☐ Yes ☐ No	
8.Do you know how to request a change in your services and supports?	☐ Yes ☐ No	
9.Do you know how to request a change in who provides your services and supports?	☐ Yes ☐ No	

10. Do you have a paid job?	☐ Yes ☐ No	*Provides opportunities to seek employment and work in a competitive integrated workplace.*
11. Do you think you might want a paid job?	☐ Yes ☐ No	
13. Do you have the help you need to look for a job if and when you want one?	☐ Yes ☐ No	
14. Can you go where you want and like to go in your local the community?	☐ Every time I want to ☐ Most of the time I want to ☐ Not as much as I would like	*Support full access to the broader community.*
15. Does someone regularly tell you about activities and events in your local community that you might be interested in?	☐ Yes ☐ No	
16. Do you have access to transportation if you need to get somewhere in your community?	☐ Every time I want to ☐ Most of the time I want to ☐ Not as much as I would like	
17. Are you able to get the support you need to do things in the community that you want to do?	☐ Every time I want to ☐ Most of the time I want to ☐ Not as much as I would like	
18. Do you do things in your community a few times every week? (Examples: go shopping, church, sports, events, see family and friends, volunteer, work, etc.)	☐ Yes ☐ No	
19. Other than family or paid caregivers, how often each week do you spend time with people who do not have disabilities?	☐ Less than 2 times/week ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times/week	
20. How long have you lived in your current residence?	Choose one: ☐Weeks ☐Months ☐Years	
21. Did you choose where you live?	☐ Yes ☐ No	*The setting was selected by the person from among setting options, including non-disability specific settings.*
22. If you are an adult and don't live in your own home/apartment, has anyone asked you if might like to do this (with support services)?	☐ Yes ☐ No	
23. Did you choose the places where you receive all of your services outside the home?	☐ Yes ☐ No	
24. Do you have access to a phone, computer, or other technology you can use in your home and to communicate with others?	☐ Yes ☐ No	*Optimizes personal initiative, autonomy, and independence in making life choices.*
25. Do you get asked to make some choices for yourself every day?	☐ Yes ☐ No	
26. Can you make decisions about your schedule, where you go, who you see, and when?	☐ Yes ☐ No	

27. Can you be alone if you want to?	☐ Yes ☐ No	*Ensures person's rights of privacy, dignity, respect and freedom from coercion and restraint.*
28. Can you have a private conversation without others listening?	☐ Yes ☐ No	
29. Is your personal information kept secure so others can't see it?	☐ Yes ☐ No	
30. Do the people who support you treat you the way you want to be treated?	☐ Yes ☐ No	
31. Do the people who support you listen to your questions or concerns?	☐ Yes ☐ No	
32. Does anyone ever physically restrain you or limit your freedom to move around?	☐ Yes ☐ No	
33. Do others knock before entering your bedroom?	☐ Yes ☐ No	
Does the person participate in Residential Services? If YES, complete Section C; If NO, STOP HERE.		☐ YES or ☐NO
Section C: Residential Services (Community-Based Residential Services or Adult Family Home Services)		
Select the type of residential services the person is receiving		☐ CWP CBRS ☐ CWP AFH ☐ID Waiver Residential Hab
Name of Service Provider	City/County:	
Question:	Response:	HCBS Setting Requirement:
1. Were you given the option to explore the possibility of living in your own place - a place that is not owned or controlled by a service provider?	☐ Yes ☐ No	*Choice of non-disability specific setting.*
2. Do you know how to request to live someplace else?	☐ Yes ☐ No	*Choice of residential setting.*
3. Do you have a lease that was explained to you and that you signed?	☐ Yes ☐ No	*Specific unit or dwelling is owned, rented or occupied under a legally enforceable agreement.*
4. Do you know your rights as a tenant and how you are protected from eviction?	☐ Yes ☐ No	
5. Can you lock and unlock your front door yourself?	☐ Yes ☐ No	*Unit has lockable entrance door person has key and who else has key is limited to only staff that need to.*
6. Are you comfortable with who else has a key to your front door?	☐ Yes ☐No	
7. Do others knock before entering your front door?	☐ Yes ☐ No	
8. Can you close and lock your bedroom door?	☐ Yes ☐ No	*Each person has privacy in their sleeping or living unit.*
9. Can you close and lock your bathroom door?	☐ Yes ☐ No	
10. Are you comfortable with who else has a key to your bedroom or bathroom?	☐ Yes ☐ No	
11. Were you given the option of a private room if you could afford it?	☐ Yes ☐ No	
12. Did you choose your roommate?	☐ Yes ☐ No	*Choice of housemate(s) and roommate.*
13. Do you like living with your roommate?	☐ Yes ☐ No	
14. Do you know how to request a roommate change?	☐ Yes ☐ No	
15. If you want to share your bedroom, can you choose who to share with?	☐ Yes ☐ No	

16. Did you decorate or help decorate the place you live (paint colors; wall hangings; furniture)?	☐ Yes ☐ No	*Freedom to furnish and decorate.*
17. Did you choose how to have your room decorated (paint color; wall hangings; furniture)?	☐	
18. Can you move the furniture where you want?	☐ Yes ☐ No	
19. Can you hang up different things on the wall if you want to?	☐ Yes ☐ No	
20. Do you make your own schedule?	☐ Yes ☐ No	*Freedom and support to control schedules and activities.*
21. Can you decide when you get up, take a bath, eat, exercise or participate in other activities at home and in the community?	☐ Yes ☐ No	
22. Do you receive supports to participate in the community?	☐ Yes ☐ No	
23. Can you watch television, listen to the radio and do things that you like when you want to?	☐ Yes ☐ No	
24. Can you eat when you want to?	☐ Yes ☐ No	*Access to food at any time.*
25. Can you eat where you want to?	☐ Yes ☐ No	
25. Can you eat what you want to?	☐ Yes ☐ No	
26. Can you request a different meal if you want one?	☐ Yes ☐ No	
27. Are snacks accessible and available anytime?	☐ Yes ☐ No	
28. Can you have visitors?	☐ Yes ☐ No	*Allow visitors at any time.*
29. Can you have visitors at any time?	☐ Yes ☐ No	
30. Can you have privacy with your visitors if you want to?	☐ Yes ☐ No	
31. Do you have the supports you need to move around your room/house as you choose?	☐ Yes ☐ No	*Physically accessible.*
32. Can you enter and exit your room/house as you choose?	☐ Yes ☐ No	
33. Do you have full access to the common areas of your home such as the kitchen, dining area, laundry, and shared living areas?	☐ Yes ☐ No	
34. Have you been given a resident handbook? (If applicable)	☐ Yes ☐ No ☐ N/A	*Policies outlining personal rights are available and accessible to the person.*
35. Do you understand the handbook or know who to ask if you have questions?	☐ Yes ☐ No ☐ N/A	
36. Do you have access to a phone, computer or other technology to communicate with others outside the home?	☐ Yes ☐ No	
37. Can you make decisions about your schedule, where you go, who you see, and when?	☐ Yes ☐ No	*Optimizes personal initiative, autonomy, and independence in making life choices.*

<table>
<tr><td colspan="3">Revisions to Person Centered Plan Required: ☐ Yes ☐ No If yes, describe areas to be addressed and target date for revisions to be done.</td></tr>
<tr><td colspan="2">Signature of Support Coordinator:</td><td>Date forwarded to:
☐ CWP QE Staff (for CWP Participants)
☐ Regional Office Monitoring Staff (for ID/LAH Participants)</td></tr>
<tr><td colspan="3"><u>TO BE COMPLETED BY CWP QE STAFF OR REGIONAL OFFICE MONITORING STAFF</u>

Remediation Plan Required: ☐ Yes ☐ No If yes, complete table below</td></tr>
<tr><td><u>Remediation Steps Required:</u></td><td><u>Who Responsible?</u>
Name HCBS provider(s) and/or Support Coordinator as applicable</td><td><u>Target Date for Completion of Each Remediation Step:</u></td></tr>
<tr><td colspan="2">☐ Check here when QE Staff/RO Monitor confirm remediation fully completed

DATE CONFIRMED:</td><td><u>Signature of QE Staff/Regional Office Monitoring Staff:</u></td></tr>
</table>

ANNUAL FINANCIAL ASSESSMENT

Person Served: ____

Instructions: This assessment should be completed at least annually prior to the Person-Centered Planning meeting. Assessment may need to be completed with a family member or staff person who knows the person served and can help answer questions if the person served is unable to answer. The person served should be encouraged to answer the questions whenever possible. Choose the answer that is closest to the answer provided. Use the spaces provided to take notes for clarification of answers. Responses and areas of concern should be discussed with the team during the PCP meeting to help identify goals that are important TO and FOR the person served.

AREA I - CURRENT FINANCIAL SITUATION	
I. Are you the person who makes the major financial decisions in your life? If no, who makes those decisions for you?	☐ No, I have a Guardian who is responsible. ☐ No, but I would like to learn. ☐ I make some but not all my decisions. I have someone who helps me. ☐ Yes, I make all my decisions without help.
2. Do you have enough money to pay your living expenses (rent, utilities, healthcare, food)?	☐ Yes ☐ No
3. Do you need assistance in making sure your bills are paid monthly?	☐ Yes, I am unable to pay bills and need someone to manage that for me. ☐ My residential provider pays my bills. ☐ Yes, I can pay my bills with some assistance. ☐ No, I can pay all my bills without help.
4. Do you have any of the following types of bank accounts in your name? Check all that apply.	☐ Savings ☐ Checking ☐ Investment ☐ ABLE ☐ Other: ________________
AREA II – INCOME / EMPLOYMENT	
5. Where are some places you get your money? Check all that apply.	☐ Job ☐ Family ☐ Social Security ☐ Other ☐ Retirement/Annuity ☐ Not Sure
6. Are you receiving Social Security?	☐ SSI ☐ Both ☐ SSDI ☐ Not Sure

ANNUAL FINANCIAL ASSESSMENT

Person Served: ____

7. A.re you receiving other public assistance? Check all that apply.	☐ Food Stamps/SNAP ☐ Temporary Assistance Needy Families (TANF) ☐ Housing Assistance ☐ Other ☐ Not Sure
8. Are you working?	☐ No, not interested ☐ Full Time ☐ No, Interested ☐ Part Time ☐ Seasonal ☐ Part Time but I want more hours
9. Would you like assistance in finding employment? *(If the individual is interested in employment, discuss referral to ADRS at the PCP meeting.)*	☐ Yes ☐ No
10. If you are working, are your wages being reported to the Social Security office? *(If no, discuss the importance of wage reporting in PCP. Discuss Benefits service!.)*	☐ No, wages are not reported. ☐ Yes, wages are reported by ___________________.
11. Have you spoken to a benefits specialist about how working will affect your Social Security, Medicaid, or other benefits? *(If the individual is interested, discuss referral to a Benefits Specialist at the PCP meeting.)*	☐ Yes ☐ No, I'm not interested ☐ No, but I would like to.
AREA III - IN THE COMMUNITY	
12. Can you identify different money denominations?	☐ Yes, all types of money ☐ Bills but not coins ☐ Coins but not bills ☐ Some money but not all money ☐ I cannot identify any types of money
13. How do you get money to buy things? Check all that apply.	☐ I withdraw cash from a bank. ☐ I receive cash from staff and/or family. ☐ I use a debit card.

ANNUAL FINANCIAL ASSESSMENT

Person Served: ____

14. What type of help do you need to make purchases? Check all that apply	☐ I do not need help. ☐ I need help handling cash. Identifying bills, waiting for change etc. ☐ I need help using my debit card. ☐ I need help with sticking to a budget. ☐ I need help with the cost of things. I don't understand price tags.
AREA IV - FINANCIAL OUTCOMES	
15. What does being "ok financially" mean to you?	
16. What are some things you want to buy or do that cost money?	
17. Do you have a personal budget / spending plan that says how you are going to spend or save your money?	☐ No ☐ Yes
SUMMARY OF ASSESSMENT (Include stated financial outcomes and potential barriers to achieving outcomes):	

Person Served: ____ Date: _______________

Completed by: ____ Date: _______________

ANNUAL FUNCTIONAL ASSESSMENT

Person Served: ______________________________ Date:____________________

Instructions: This assessment should be completed at least annually prior to the Person-Centered Planning meeting. Assessment may need to be completed with a family member or staff person who knows the person served and can help answer questions if the person served is unable to answer. The person served should be encouraged to answer the questions whenever possible. Choose the answer that is closest to the answer provided. Use the spaces provided to take notes for clarification of answers. Responses and areas of concern should be discussed with the team during the PCP meeting to help identify goals that are important TO and FOR the person served.	
AREA OF DAILY LIFE: Communication preferences, Activities of Daily Living; Personal Preferences; Leisure activities; Vocational Needs	
How do you communicate best?	☐ Verbal ☐ Sign Language ☐ Gestures or Body Language ☐ Pictures or communication board
Do you need help with activities of daily living? *i.e., bathing, toiletings, other hygiene, dressing, eating, medications, etc. If yes, Please explain which ADLs the person needs support for.*	☐ Yes ☐ No
Do you need supports in order to work in the community?	☐ Yes ☐ No
If yes, what type of supports do you need?	☐ Job Coach ☐ Job Accommodations ☐ Other:
If no, are you interested in obtaining a job? If yes, complete Employment Assessment.	☐ Yes, ☐ No
Describe what a really good day looks like to you? What would you do, where, with whom? Do you have any interests or hobbies? What do you do for fun?	
AREA OF COMMUNITY LIFE: Family/Home Situation; and Social Supports	
Where do you live? Who lives in the home with you?	☐ I live on my own ☐ I live with family ☐ I live in a group home

ANNUAL FUNCTIONAL ASSESSMENT

Person Served: ________________________________ Date:____________________

<table>
<tr><td>Who are the people who help and support you? Check all that apply.</td><td>☐ Parents
☐ Siblings
☐ Other Family</td><td>☐ Friends
☐ Staff / Paid Support
☐ Other:</td></tr>
<tr><td colspan="3">AREA OF HEALTHY LIVING: Health Supports; Physical Supports</td></tr>
<tr><td>What type of supports do you need to maintain your health? Check all that apply.</td><td>☐ Help with medications
☐ Help making/keeping appointments
☐ Transportation to/from appointments</td><td>☐ Help with healthy diet
☐ Help with exercise
☐ Other:</td></tr>
<tr><td>Do you need physical supports? If yes, list type of support.</td><td colspan="2">☐ Yes
☐ No</td></tr>
<tr><td colspan="3">OUTCOMES: Areas of strength, opportunities for growth; needed supports and resources.</td></tr>
<tr><td colspan="3">What are some of this person's strengths? List the skills or knowledge this person has that allows them to be independent.</td></tr>
<tr><td colspan="3">What are some opportunities for growth for this person? List potential barriers or lack of skills that could be improved to assist this person in becoming more independent.</td></tr>
<tr><td colspan="3">What supports, services, or resources are available to assist this person? Identify additional community supports, paid supports or natural supports this person does not already receive that would be beneficial.</td></tr>
<tr><td colspan="3">Other concerns (health, safety, etc.) or recommendations.</td></tr>
</table>

Completed by: ____

Everyone has Human Rights and Responsibilities, let's see how I feel about that.

Instructions: This Rights Assessment is to be reviewed at minimum annually at the Person-Centered Plan meeting. The Support Coordinator will review each right with the person served. The person served will indicate their level of understanding or ability to exercise each right using the scale 1-5 at the top of the page. The Support Coordinator will then record the corresponding number in the "Selection" column on the right. At the end of the assessment, the total number of each column will be recorded below that column i.e., the person served selected a 5 in the area of 10 rights. Record "10" at the bottom of the 5 columns. Make notes in the "Selection" column.

	Person Served: ________________ Completed by: ________________						
		1	**2**	**3**	**4**	**5**	**Selection**
1	My Equality: I have the right to be treated as an equal citizen where I live, just like everyone else.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I feel I am treated almost the same as other people	I am always treated equally.	
2	My Safety: I have the right to be safe from physical, verbal, emotional or sexual abuse.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I feel safe most of the time	I always feel safe.	
3	My Home and family: I have the right to be part of a family.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I have a family but would like to see them more	I am happy with how often I see my family & friends.	
4	My Privacy: **HCBS** I have the right to privacy. I can have a private bedroom or choice of roommate with furniture arranged to maximize privacy. I can dress, shower, receive/send mail, speak to others and be alone.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I have privacy most of the time.	My privacy is always respected.	
5	My Independent living: I have a right to live as independently as possible in a community of my own choosing, in a setting that I choose.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	Others support my independent living, just not as much as I want.	My independent living choices are supported.	

Everyone has Human Rights and Responsibilities, let's see how I feel about that.

	Person Served: ________________ Completed by: __________________						
		1	**2**	**3**	**4**	**5**	**Selection**
6	My Lifestyle: I have a right to live and receive services in a non-disability setting, just like my non-disabled peers.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	Others support my lifestyle choices, just not as much as I want.	My lifestyle choices are supported.	
7	My Education: I have the right to an equal education, side by side with everyone else.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	Others support my education choices, just not as much as I want.	My education choices are supported.	
8	My Health: I have the right to the best possible health care, and to make my own health care choices.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	Others support my health choices, just not as much as I want.	My health choices are supported.	
9	My Access: I have an equal right to be able to get to and use public spaces and public services.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	Others support my access to services & spaces, just not as much as I want.	My access to services & spaces is supported.	
10	My Political life: **HCBS** I have an equal right to vote and have a say in laws and policies that affect me.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	Others support my political life, just not as much as I want.	My thoughts on politics are respected all of the time.	
11	My Guardianship: I may have a guardian, but my thoughts and feelings about my life matter to that person.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	My guardian supports my choices, just not as much as I want.	My guardian considers my thoughts all the time. Or I do not have a Guardian	

Everyone has Human Rights and Responsibilities, let's see how I feel about that.

	Person Served: ________________ Completed by: __________________						
		1	**2**	**3**	**4**	**5**	**Selection**
12	My Informed choice: I have the right to be informed of choices that are available to me, not just the ones others think I should choose.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	Others inform me of choices available to me most of the time.	I am always informed of all available choices.	
13	How I am treated: I have the right to be treated as any other person is treated, with respect and dignity.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	Others treat me with dignity and respect most of the time.	I am always treated with dignity and respect.	
14	My Goals: I have a right to choose my own goals, and to pursue those goals in the way I choose.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	Others support my goals, just not as much as I want.	I have excellent support to achieve my goals.	
15	My Religious choices: **HCBS** I have the right to worship in the place and faith of my choosing, not just where someone else wants to take me.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I worship when, how and where I want most of the time.	I choose when where and how to worship all of the time.	
16	Sharing my information: I have the right for my personal information to be respected and kept private, just like everyone else.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	My personal information is respected and kept private most of the time.	My personal Information is always respected.	
17	My Employment: I have a right to work at a place of my choosing and be paid a fair wage for work and know what that wage is.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I did not choose where I work and am not sure about my pay.	I chose where I work and am informed of my wages.	

Everyone has Human Rights and Responsibilities, let's see how I feel about that.

	Person Served: ________________ Completed by: __________________						
		1	**2**	**3**	**4**	**5**	**Selection**
18	My Benefits: I have a right to be informed about what benefits I receive and be involved in decisions about those benefits.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I know I receive benefits, but I am not involved in managing them.	I am informed on my benefits and stay involved in decisions that affect them.	
19	My Finances: **HCBS** I have a right to be informed about my money and be involved in decisions about how my money is spent and to access that money when I want.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I am able to buy the things I want, but I am not involved in managing my money.	I am involved in how my money is managed and decide how to spend it and have access when I want.	
20	My Property: **HCBS** I have the right to own personal property and possessions and to not have others go through them without my permission.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	My personal property and possessions are respected most of the time.	My personal property & possessions are respected all of the time.	
21	My Social Life: **HCBS** I have a right to a healthy social life that involves people, activities and schedules of my choosing.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I have limited access to social activities or I do not get to choose my activities or set my own schedule.	I live a full social life that includes my friends. I get to set my own schedule and choose my own activities.	
22	Leading My PCP: I have the right to choose who attends my PCP & to lead my PCP in the manner that I choose.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I can choose some things about my PCP, but not all of it.	This is my PCP and I can always lead and choose.	

Everyone has Human Rights and Responsibilities, let's see how I feel about that.

	Person Served: ________________ Completed by: ________________						
		1	**2**	**3**	**4**	**5**	**Selection**
23	My Freedom from Restraints: I have the right to be free from restraints, either by medications to control my behaviour, or physical holds to contain me.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I am aware of my medicines and am mostly free from restraints.	I am not restrained in any way.	
24	My Personal Responsibility: I have a personal responsibility not to hurt myself or others, and not to break the law, just like everyone else.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I follow the same rules as everyone else most of the time.	I follow the same rules as everyone else all of the time.	
25	My Rights Restrictions: I know what rights restrictions are, and am involved in the choices that are made on my behalf.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I am aware of the restrictions to my rights, just not as much as I want.	I am not experiencing any rights restrictions.	
26	My Freedom of Movement: **HCBS** I have the right to move within my physical environment and to have locks and a key to my home and bedroom doors and to control access to those keys.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I have a lock to my front door with a key, but not to my bedroom. Or people have a key that I don't want to have a key.	I have locks on my front door and bedroom door and only people I approve of have a key.	
27	My tenant rights: **HCBS** I have a right to a lease / residency agreement that provides protection to me as a tenant similar to Alabama Landlord-Tenant laws.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I have a lease / residency agreement but I didn't sign it and don't understand it.	I have lease/residency agreement that I signed and I understand it.	
28	My Relationships: **HCBS** I have a right to healthy relationships with people and to visit with or be visited by them at any time.	Never / Person does not understand.	Sometimes	I don't know about this / I would like to learn more.	I have friends but am limited to when and where I can visit them.	I have friends and am able to see them when and where I want.	

Everyone has Human Rights and Responsibilities, let's see how I feel about that.

	Person Served: _________________ Completed by: __________________						
		1	2	3	4	5	Selection
	TOTAL						

Any right scored as less than a 5 should be discussed in the Person-Centered planning meeting. Team should discuss each Right and agree on which are most important **TO and FOR** the person served to learn and focus on those rights in the upcoming Plan year. All supports that are needed to protect and promote the individual's rights are to be documented in the appropriate section of the Person-Centered Plan.

Right to be addressed	Responsible Provider.

Grievance Procedure:

I have been provided with a copy of all providers' grievance procedures, in addition to all team members who participated in this assessment. These documents have been explained to me and I understand that if I have any questions or concerns that I may discuss these with any member of my team. Contact information for Advocacy and Department of Human Resources is included with this document.

Advocacy 1-800-367-0955
ADAP 205-348-4928
DHR Adult Abuse Hotline 1-800-458-7214

Everyone has Human Rights and Responsibilities, let's see how I feel about that.

***Please include contact information when signing:**	Signature	Date
Example: John Doe, Provider name *Phone number, email address*		
Person Served:		
Support Person/Responsible Relative/Guardian:		
Support Coordinator:		
QDDP:		
QDDP:		
Other:		
Other:		

***Please note that this document is only valid for 365 days from date signed.

ANNUAL SAFETY ASSESSMENT

Person Served: ________________________

Instructions: This assessment should be completed at least annually prior to the Person-Centered Planning meeting. Assessment may need to be completed with a family member or staff person who knows the person served and can help answer questions if the person served is unable to answer. The person served should be encouraged to answer the questions whenever possible. Choose the answer that is closest to the answer provided. Responses and areas of concern should be discussed with the team during the PCP meeting to help identify goals that are important TO and FOR the person served.

If the Person Served is receiving Self-Directed services, the Support Coordinator will be responsible for completing the appropriate section(s) of this assessment.

AREA I – PERSONAL SAFETY

Area I is to be completed by all providers (residential, day, support coordinators or family) for persons served regardless of services that are provided.

	YES	NO	WITH ASST	N/A
1. Is this person able to express their wants and needs in an understandable way?	☐	☐	☐	☐
2. Does the person express to family or staff when they are hurt, sick or uncomfortable?	☐	☐	☐	☐
3. Is this person able to state or provide their personal information?	☐	☐	☐	☐
4. Does this person carry identification?	☐	☐	☐	☐
5. Can this person describe what an emergency is?	☐	☐	☐	☐
6. Does this person know how to obtain assistance in an emergency? (This includes going to a neighbor, calling 911, shouting for help etc.)	☐	☐	☐	☐
7. Does this person know appropriate and inappropriate uses of 911?	☐	☐	☐	☐
8. Does this person know their medical history?	☐	☐	☐	☐
9. Does this person know their medications?	☐	☐	☐	☐
10. Does this person know their doctor's name?	☐	☐	☐	☐
11. Does this person know how to contact their responsible relative?	☐	☐	☐	☐
12. Does this person know what their allergies are?	☐	☐	☐	☐
13. Does this person have a medical ID?	☐	☐	☐	☐
14. Can this person identify abuse?	☐	☐	☐	☐
15. Can this person identify neglect?	☐	☐	☐	☐
16. Can this person identify exploitation?	☐	☐	☐	☐
17. Does this person know how to report abuse, neglect, exploitation?	☐	☐	☐	☐

ANNUAL SAFETY ASSESSMENT

Person Served: ________________________

AREAS TO DISCUSS:

AREA II – HOME SAFETY

Area II should be completed by residential providers, personal care, or support coordinators to assess the safety skills inside the home. If the provider completing the assessment does not provide service in this area, check the box for "Does not Apply" below.

☐ This section does not apply	YES	NO	WITH ASST	N/A
1. Does this person have a key or door code to their residence?	☐	☐	☐	☐
2. Is this person able to adjust bathing water temperature to a safe and comfortable temperature?	☐	☐	☐	☐
3. Is this person able to bathe independently?	☐	☐	☐	☐
4. Is this person able to dress independently?	☐	☐	☐	☐
5. Is this person able to go to the restroom independently?	☐	☐	☐	☐
6. Does this person require bed checks? How often?	☐	☐	☐	☐
7. Does this person know how to exit the home safety in the event of a fire?	☐	☐	☐	☐
8. Does this person know where the safe area of the home is in the event of severe weather?	☐	☐	☐	☐
9. Does this person understand how to use cleaning chemicals?	☐	☐	☐	☐
10. Does this person know how to use the microwave?	☐	☐	☐	☐
11. Does this person know how to use a stove?	☐	☐	☐	☐
12. Does this person know how to use an oven?	☐	☐	☐	☐
13. Does this person know how to use a fire extinguisher?	☐	☐	☐	☐

AREAS TO DISCUSS:

ANNUAL SAFETY ASSESSMENT

Person Served: ________________________

AREA III – COMMUNITY SAFETY				
Area III is to be completed by providers (Day services, personal care, residential, support coordinators) who serve individuals in the community. If the provider completing the assessment does not provide service in this area, check the box for "Does not Apply" below.				
☐ This section does not apply	YES	NO	WITH ASST	N/A
1. Does the person served know what it means to be lost?	☐	☐	☐	☐
2. Does the person served know what to do in case they become lost in the community?	☐	☐	☐	☐
3. Is the person served able to identify common community safety signs? (Exits, Hospital, crosswalks, caution, wet floor etc.)	☐	☐	☐	☐
4. Is the person served able to use public transportation?	☐	☐	☐	☐
5. Is the person able to cross the street safely?	☐	☐	☐	☐
6. Is the person able to walk in a parking lost safely?	☐	☐	☐	☐
7. Does this person approach and talk to strangers?	☐	☐	☐	☐
8. Does this person give out their personal information to strangers?	☐	☐	☐	☐
9. Does this person give away money when asked?	☐	☐	☐	☐
10. Does this person know how to exit the vehicle in case of a fire?	☐	☐	☐	☐
11. Does this person know what to do in the event of a car accident?	☐	☐	☐	☐
12. Can this person use stairs / escalator?	☐	☐	☐	☐
13. Can this person use an elevator?	☐	☐	☐	☐
14. Does the person served know to only use stairs in the event of a fire?	☐	☐	☐	☐
15. Does this person know how to respond to severe weather while in the community?	☐	☐	☐	☐
16. Is this person aware of medical or physical needs? (diet, medications, cane, etc.)	☐	☐	☐	☐
AREAS TO DISCUSS:				

ANNUAL SAFETY ASSESSMENT

Person Served: ___________________________

AREA IV – EMPLOYMENT

Area IV is to be completed by providers who provide employment services (ESSG, Job Coaching) to persons served. If the provider completing the assessment does not provide service in this area, check the box for "Does not Apply" below.

☐ This section does not apply	YES	NO	WITH ASST	N/A
1. Is this person aware of company safety policies?	☐	☐	☐	☐
2. Does this person require PPE to be used on the job? (safety glasses, steel toed shoes, slip resistant shoes, etc.)	☐	☐	☐	☐
3. Is this person able to recognize and identify workplace safety signs?	☐	☐	☐	☐
4. Does this person know where the exits are located?	☐	☐	☐	☐
5. Does this person know how to exit the building in case of fire?	☐	☐	☐	☐
6. Does this person know where to meet outside in case of fire?	☐	☐	☐	☐
7. Does this person know who to report safety concerns to?	☐	☐	☐	☐
8. Does this person know where the severe weather shelter is?	☐	☐	☐	☐
9. Does this person know how to use a fire extinguisher?	☐	☐	☐	☐

AREAS TO DISCUSS:

SUMMARY OF ASSESSMENT:

Application and Setting Review Form

Provider Name:	
Date new application received:	**Provider Status:** ☐**New** ☐**Existing**

Part A To be verified by the Regional Community Services Director– NOTE: Expanding providers complete 1-3; New providers complete 3	
1. Is the agency currently on a Provisional Certification status?	☐ **Yes** ☐ **No**
2. Has the agency been on a Provisional Certification within the last two regular site visits?	☐ **Yes** ☐ **No**
If the answer to 1 or 2 is "YES", do not proceed with application! Return to OCA! **If the answer to 1 and 2 is "NO", return application to OCA. OCA will forward to the Divisional Director for completion.**	
3. Is the setting approved for a 6-month Temporary Operating Authority (TOA) following Life Safety inspection?	☐ **Yes** ☐ **No**
Additional Comments **(Setting Form Must Be Approved By Regional Office Before Going to Life Safety)**:	
Name of Community Services Director:	**Date:**
Return to the Office of Certification Administration (OCA)	

Part B To be completed by Regional Community Services (RCS) Office	
1. Is the setting adjacent to or under the same roof as a building that houses a publicly or privately-operated setting which provides inpatient institutional care: skilled nursing setting (SNF), immediate care setting for individuals with intellectual disabilities (ICF/IID), institute for mental disease (IMD), or hospital?	☐ **Yes** ☐ **No**
2. Is the setting located on the grounds of, or immediately adjacent to, a building that is a public institution which provides impatient institutional care (Skilled Nursing Setting (SNF), Intermediate Care Setting for Individuals with Intellectual Disabilities (ICF/IID), Institute for Mental Disease (IMD), or hospital?	☐ **Yes** ☐ **No**
3. Does the setting otherwise have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS and therefore, presumed institutional? a. If the answer is YES, what evidence is provided to overcome the presumption of an institutional setting?	☐ **Yes** ☐ **No**
4. Does the setting have more than 6 beds?	**Yes No**
5. Would this proposed setting be located on the same street, court, etc., where these types of settings constitute more than 25% of all settings?	**Yes No**
6. Is the setting adjacent (next to or shares a property line) to another setting?	**Yes No**
IF EITHER ANSWER TO 4-6 IS YES, DO NOT PROCEED, SIGN FORM AND RETURN TO OFFICE OF DD CERTIFICATION, OTHERWISE, RETURN TO OCA.	
7. Is the setting physically accessible, and free from obstructions such as steps, lips in a doorway, narrow hallways, etc., or otherwise have any other safety concerns such as lighting, unsanitary conditions, exposed electrical wiring, area known for violent crimes, drug use, etc.?	☐ **Yes** ☐ **No**
8. Is the site recommended for Life Safety inspection?	☐ **Yes** ☐ **No**
Additional Comments/Observations:	
Name of person completing Assessment:	**Date:**
Return to the Office of Certification Administration (OCA)	

Part C To be completed by the Office of Certification Administration	
Sent to Life Safety:	**Date:**
Additional Comments:	

OCA Director Signature	**Date:**

PCP Timeline

EVENT	Waitlist to Services	Redetermination	6-Month Update (Required by AMA-TCM)
Support Coordinator notifies the Team of the Team meeting date including time and place	30-Days Prior to Team Meeting	At least 30-Days Prior to Team Meeting	At least 30-Days Prior to Special Team Meeting
Direct service professional will submit assessments as outlined in Operational Guidelines 4.8 and 5.10 to Support Coordinator. In addition, the HCBS transition to compliance information for the site relevant to individual should be submitted.	Within 30-days of enrollment onto waiver	30-days prior to Team meeting	If a change has occurred, then submit those assessments that were completed and the follow-up data including Quarterly reports at least 21-days prior to Special Team
Support Coordinator will schedule and hold **Premeeting** with individual, family members and direct service provider either individually or as a team. This premeeting is to ensure that all necessary assessments and information has been provided to identify the goals/outcomes for the individual.	At least 14-days prior to Team Meeting	At least 14-days prior to Team Meeting	If SC does not have the Quarterly reports with progress towards the outcomes, then hold a pre-meeting. Direct Service Professional ensure the Support Coordinator has quarterly updates at least 14-days before the Special Team Meeting.
Support Coordinator will distribute draft of PCP to Team members	At least 7-days prior to Team Meeting	At least 7-days prior to Team Meeting	At least 7-days prior to Team Meeting
PCP Team Meeting	The Support Coordinator, QIDP and family members work collaboratively with individual to develop strategies to obtain identified outcomes.	The Support Coordinator, QIDP and family members work collaboratively with individual to develop strategies to obtain identified outcomes.	The Support Coordinator, QIDP and family members work collaboratively with individual to develop strategies to obtain identified outcomes.
Support Coordinator submit Waiver Packet, which includes the PCP, to ADMH Waiver Coordinator via ADIDIS	Within in 30 days of coming onto waiver. Must be submitted for services to begin.	By the 15th of the month	Not Applicable unless there are changes to services. Then the PCP should be submitted as soon as it is finalized and signed by Team members.
Support Coordinator emails QIDP the signed final version of the PCP	Within 30 days after PCP meeting	Within 30 days after PCP meeting	Within 30 days after PCP meeting
Support Coordinator sends waiver documents to direct service provider	By the end of the month	By the end of the month	By the end of the month
Request for Action for Changes to PCP: SC submit documents to provider after a response is provided by RO	Not Applicable	Within one week of RO response to RFA.	Within one week of RO response to RFA.

Rental or Residency Agreement
Guidelines

In accordance with CMS regulations 42 CFR 441.301 (c) (4) (vi), Landlords/Providers must have a lease or other legally enforceable written agreement providing protections for Tenants/Individuals receiving HCBS Waiver services in provider owned and controlled settings certified by ADMH. Such agreements may take the form of a Rental or Residency Agreement that ensures Tenants/Individuals receiving HCBS Waiver services in provider owned and controlled settings are provided the same protections afforded others under Alabama Tenant Laws, including protections from eviction. The following guidelines shall be followed to ensure a Rental or Residency Agreement complies with CMS regulations.

RENTAL OR RESIDENCY AGREEMENT

The Residential/Residency Agreement must include the following:

1. The individual's/tenant's or legal guardian's name, if applicable, and the landlord's/provider's name for whom the agreement is being entered.

2. The location/address of the property subject to the agreement.

3. Period for which the agreement is binding.

4. The specific monthly rent or room and board to be paid by the individual/tenant.

5. The pro-rated rate for partial month occupancy based on move-in or move-out date.

6. The specific services and supports to be provided in exchange for payment of rent or room and board (e.g., utilities, meals, laundry, etc.)

7. Date by which monthly rent or room and board payment is due and specific penalty, if any, for late payment.

8. The specific conditions under which the rental or room and board rates can be changed. (Note the Landlord/Provider must give the tenant/individual or Legal Guardian, if applicable, at least 30 days prior notice of any rate increase and amend the written agreement to reflect the new rate)

9. The Landlord's/Provider's refund policy in instances of Tenant's/Individual's hospitalization, death, transfer to a nursing facility or other health care facility and/or tenant's/individual's voluntary or involuntary permanent move from the residence.

10. The Landlord's/Provider's policy regarding pets or service animals on property.

11. The Landlord's/Provider's eviction policy or involuntary termination of residency agreement. (Note such must be compliant with applicable Alabama Landlord Tenant Act)

12. If the Landlord/Provider determines that they no longer can provide Residential services to a tenant/ individual, or the landlord/provider follows requirements of Alabama landlord/tenant law relating to eviction as required, the tenant/individual may be required to move. In this event, the tenant/individual will receive advanced notice and have the right to appeal the decision. In the event the individual chooses to initiate an appeal, the landlord/provider may not

terminate the Residential services until the appeal process is fully complete and then only if the decision was decided in the landlord/provider's favor. The following steps must occur if the landlord/provider proposes to terminate services:

A. The landlord/provider will notify the individual or legal representative, the ADMH Regional Office, and the Support Coordinator, in writing, of the intended service termination.

B. The notice will be provided at least 30 days before the proposed effective date of service termination.

C. The written notice of a proposed service termination will include all of the following elements:

I. The reason for the action.
II. A summary of measures taken to minimize or eliminate the need for service termination, and why these measures failed to prevent the termination (this element will not be required when service termination is a result of the program ceasing operation).
III. The individual's right to appeal the termination of services.

13. The Rental or Residency Agreement must contain the signatures of both the Landlord/Provider and Tenant/Individual and Date of Signatures.

Note: The above Rental or Residency Agreement must be presented to the Tenant/Individual in language and terms which the Tenant/Individual or Legal Guardian, if applicable, understands.

Rights and Responsibilities Agreement

The Rights and Responsibilities Agreement may be included as a section of the Rental or Residential Agreement or must be in a separate agreement. This agreement must include all Rights as afforded those receiving HCBS Waiver services under CMS Regulations 42 CFR 441.301 (c) (2) (xiii) and CFR 441.503 (a) (1) (vi) (F). The following must be included to comply with CMS regulations:

1. The tenant's/individual's or legal guardian's name, if applicable, and the landlord's/provider's name for whom the agreement is being entered into.
2. Tenant's/Individual's Responsibilities to maintain his/her living space and not engage in activities that may disrupt or potentially cause harm to other individuals/tenants.
3. Tenant's/Individual's Rights to:
    - Live under a legally enforceable agreement with protections substantially equivalent to landlord/tenant laws of the State of Alabama and other applicable laws or rules of the county, city or other designated jurisdiction in which the individual resides.
    - Privacy in their sleeping/living unit; including the right to have entrance doors lockable with individual and only appropriate staff having access to keys. (Note that staff's access to bedroom is limited to situations as described in the residency agreement and to emergencies where the health/safety/well-being of the occupants is jeopardized.
    - Choice of roommates for individuals sharing units or bedrooms.

- Freedom to furnish and decorate their living and sleeping areas as long as decorations do not damage the unit. (Note that in common areas of shared living arrangement, tenants/individuals are expected to collaborate with their housemates/roommates.)
- Freedom and support to control their own schedules and activities.
- Freedom and support to have access to food at any time unless restricted due to modifications in the person-centered plan. (Note that such modifications can include restrictions due to individual's/tenant's personal health, financial plan as included in the person-centered plan and/or exhaustion of board/food allowances as included in the lease/rental agreement)
- Have visitors of their choice at any time. (Note that supports may be needed to protect the rights and privacy of others living in the home)
- Control over Personal Resources, including access and management of their personal funds.

4. There shall be no modifications of the right to live under a legally enforceable agreement as described above. Modifications to any of the other rights articulated above may only occur when a condition presents a significant risk to the individual's health and/or safety that is supported by specific assessed need, justified in the individual's Person-Centered Plan and compliant with all ADMH-DDD Due Process Procedures.

5. The signatures of both the Landlord/Provider and Tenant/Individual and Date of Signature.

Note: The Rights and Responsibilities Agreement must be presented to the Tenant/Individual in language and terms which the Tenant/Individual or Legal Guardian, if applicable, understands.

ADMH Approved: ___________________________________ Date: 2/10/2023

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

Factors	Indicators	Services Provided by the Organization			Other Notes
		Support Coordination	Non-Congregate	Residential and/or Day	
Factor One	8	√ (7 indicators)	√	√	Indicator G not applicable to Support Coordination
Factor Two	5	√	√	√	
Factor Three	4	√	√	√	
Factor Four	6 (100% compliance)	√	√	√	
Factor Five	5 (100% compliance)	√ (4 indicators)	√	√	Indicator E not applicable to agencies not administering medications
Factor Six	4 (100% compliance)	√ (3 indicators)	√	√	Indicator D not applicable to Support Coordination
Factor Seven	4	√	√	√	
Factor Eight	11	¥ (6 Indicators)		√	Indicators A, E, I, J, K not applicable to Support Coordination
Factor Nine	3	√	√	√	
Factor Ten	3	√	√	√	
Factor Eleven	5	√	√	√	
Factor Twelve	3		√		
Factor Thirteen	5	√			
Number of Indicators Scored	**51** **Max Score = 153**	**42** **Max Score = 126**	**35** **Max Score = 105**	**43** **Max Score = 129**	**For organizations providing services in more than one category, indicators are added as applicable**

Revised August 17, 2022

Admit to: DD Crisis Unit_____
RM – ______
REFERRED FROM- ______

ADMH-DDD Crisis Care

Pre-Screen Evaluation

Today's Date ___________

Section 1 Patient Information and Identification

Patient Name: ______________________ Date of Birth: ______________________

Address: ______________________ Phone: ______________________

City/State: ______________________ Zip: ______________________

Occupation: ______________________ Current Employer: ______________________

Ethnicity: ❒African Indian or Alaska Native ❒Asian ❒Black or African American ❒Hispanic or Latino ❒Native Hawaiian or Pacific Islander ❒White ❒Other: ____________

Marital Status: ❒Single ❒Married ❒Widowed ❒Separated ❒Divorced Gender: M /F

Insurance Information: Include ID#, Group #, Phone #, IRF-PAI Code (please circle) SSN: ______________

Primary: ______________________

Secondary ______________________

Other ______________________

Code Status/Advanced Directive: ______________________

Personal Contact Data:

Parent/Guardian/Other : ______________________ Phone: ______________

Family Contact: ______________________ Phone: ______________

Family Contact:: ______________________ Phone: ______________

Pre-Hospital Living Setting: ______________ Pre-Hospital Living with: ______________

Prior Admission to Inpatient Psych: ______________ Education Level : ______________

Referral Source: ______________ Date of Referral: ______________

Referring Caregiver______________ Patient Location: ______________

Other Physicians: ______________________

Case Manager /Care Coordinator Contact : ______________________

Referral Diagnosis: ______________________

Co-Morbidities: ______________________

Date of Onset: ______________________

1. ❒ The patient must be at least 19 years of age.
2. ❒ The patient must have a Developmental Disability and a provisional DSM-V-TR Axis 1 psychiatric diagnosis.
3. ❒ The patient must be medically stable and able to participate in the psychosocial programming on the unit. Patients who are medically ill, bedfast, or require services by medical specialist are not appropriate for the unit.
4. ❒ The patient must meet at least one of the following:

Inappropriate performance of activities of daily living as evidenced by:

- Inappropriate hygiene
- Psychomotor agitation or retardation
- Severe disturbances in appetite or sleep

Impaired safety as evidenced by:

- Inappropriate, depressed, agitated mood
- Suicidal ideation, threat, gesture, or attempt

Impaired thought process as evidenced by:

- Verbal or behavioral disorganization
- Thought disorganization, hallucinations, paranoid ideation, phobias, etc.
- Impaired reality testing
- Bizarre or delusional behavior
- Disorientation or memory impairment to the degree of endangering the patient's welfare
- Severe withdrawal or catatonia

Impatient treatment required due to:

- Failure of outpatient therapy
- Failure of social or family functioning which places patient at risk
- Treatment in a less restrictive environment not feasible due to patients behaviors

The patient needs inpatient evaluation:

- Need for 24-hour skilled nursing and intensive observation
- Reoccurrence of psychosis not responding to outpatient treatment

Allergies: ______________________ Weight: __________ Height: ______________

Diet: ______________ Hearing: ______________ BMI __________

Synopsis of recent Crisis Issues/behaviors: ____

____

____

____

____

Psychiatric history: ____

____

____

Medical History ____

____

____

____

Evaluation Outcome

______ Accepted for Inpatient Admission ______ Recommend Op Services __ Recommend Medical Inpatient

Specific non-admit Reason: ______________________________

Disclosure Statement discussed: ❒Yes ❒No Guardian agrees to Admission: ❒Yes ❒No

Bed Available: ❒Yes ❒No Anticipated admission date: __________ Order Received: __

Communication Notes:

Note: (Summary of all communication with the Psychiatrist to include the process of obtaining an order to admit)

______ ______________________________

______ ______________________________

______ ______________________________

______ Pt. not appropriate for admission at this time.

______ Pt. needs to be admitted at this time for aggressive, multidisciplinary course of therapy and daily medical management in an acute setting to safely and effectively manage his/her rehabilitation needs and co-morbid conditions.

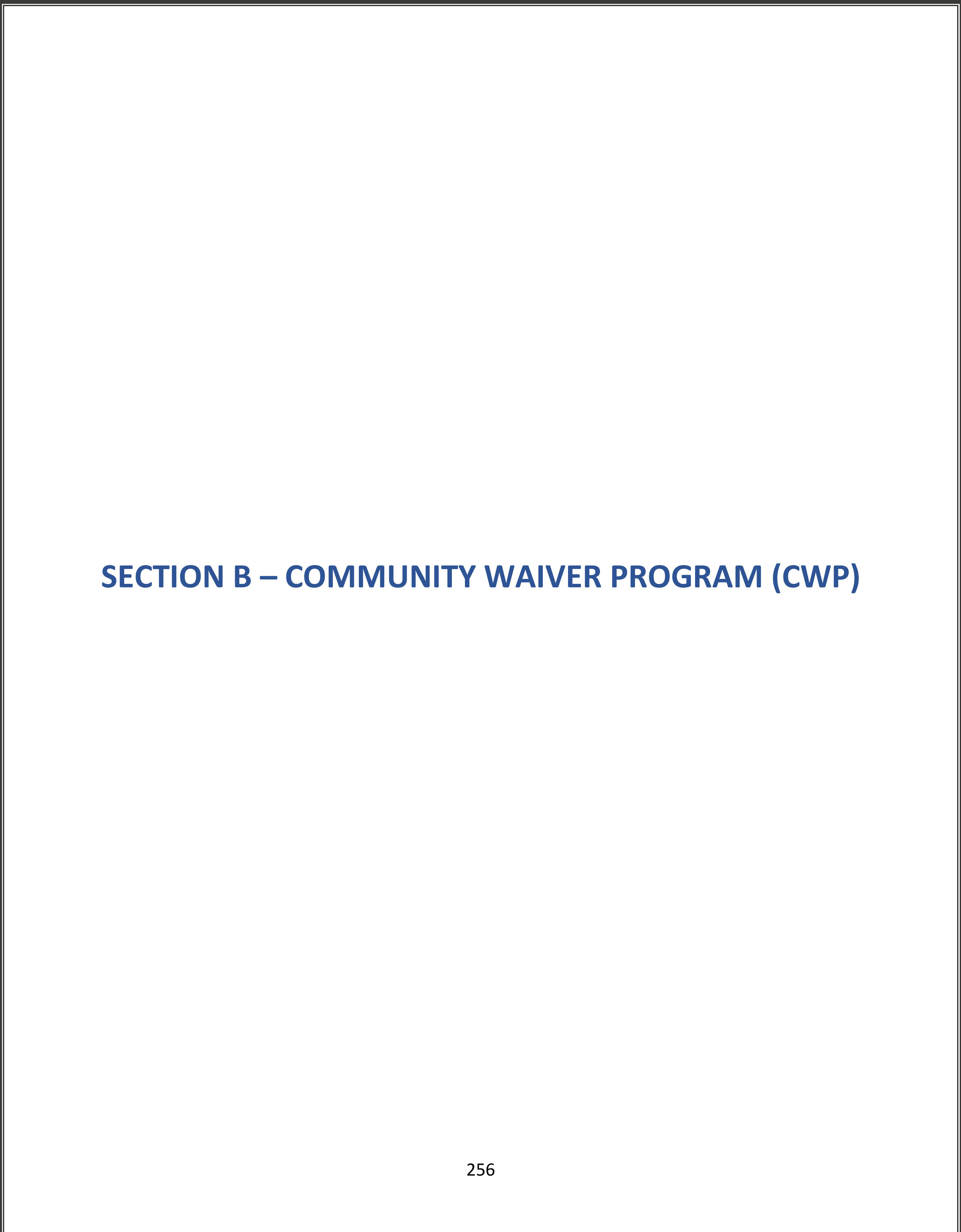
______________________________ ______
Medical Doctor Date

Completed: ______________________________ ______
Intake Coordinator Date

ADMH DDD Provider Money Management Guidance

	Individual	Provider	Outcomes
Rights & Privileges	• Must be given the option to decide how to spend, save, keep, give away, invest, or direct their money • Must be provided the option to possess a checking or savings account, or other means to control his/her funds (i.e., debit card, refillable debit card, or personal checks, etc.) • Must be offered informed choices to control monetary resources • Must be offered training in utilizing their own money	• Offer to assist individuals served with money management (individualized budget) of their funds • Ensure timely/prompt access of monetary funds as requested by individuals served • Ensure that individual needs are met and sustained • Provide training to individuals served on how to access and manage their money • Any modifications of conditions of HCBS must be supported by a specific assessed need and justified in the PCP	• Optimize individuals served independence in accessing and using money • Ensure individual preferences are supported and rights are protected • Ensure services and supports are self-directed
Access to Money	• Must be able to access funds at will • Provided the option to manage his/her own personal funds	• Maintain a separate account for individuals served • Provide individuals served monthly reports of expenditures • Offer individuals served the option to create an Able Savings Plan to store monies with a maximum allowable balance of **$100,000** • Ensure that available funds on-site (petty cash) do not exceed **$300** per individual • Provide an assessment tool to help manage funds for individuals served who choose not to manage their own funds	• Promote financial independence for individuals served • Ensure individuals served spend their money in a manner reflecting their personal choices/preferences
Financial Accountability	• Must be provided monthly financial statements to see how individual funds are utilized • Must be given the option to participate in the monthly, individualized budget process • Must be assured by the provider agency that their monies are kept safe and protected from fraud or misuse	• Implement a check and balance system to include monthly review of individualized financial statements or expenditure reports with designated staff • Offer monthly meetings with individuals served to discuss individual budgets and expenditures (i.e., picture board or graphics) • Implement an internal, electronic financial monitoring and tracking system for individual budget expenditures (i.e., Quicken or a Microsoft Excel spreadsheet) • Hire or consult with a financial expert or certified accountant	• Minimize risks of budgetary inconsistencies, fraud, or improper documentation/use of federal/state funds • Allow for financial maintenance/sustainability in the event of auditing or staff changes • Engage individuals served in seeing how their monies are disbursed according to their preferences
Auditing	• Must be made aware that individuals' funds will be subject to auditing and reporting	• Maintain a filing system of receipts (can be scanned copies electronically for additional safekeeping) • Required compliance audits are performed according to provider entity type (See Additional Resources) • Maintain fiscal records for a minimum of **3 year**	• Ensure fiscal integrity • Ensure all financial transactions and recordkeeping have been properly documented in accordance with state and federal mandates • Validate individual services/supports costs
Additional Resources	• Microsoft Word - AUDIT GUIDE 2016.rtf (alabama.gov) • 2.-Internal-Audit-Managers-Letter.pdf (alabama.gov) • HCBS Rule Residential Setting-Specific Transition to Compliance Plan.xlsx (alabama.gov) • HCBS Rule Non-Residential Setting-Specific Transition to Compliance Plan.xlsx (alabama.gov)		

For more information, please contact your Regional Community Services Office



SECTION B – COMMUNITY WAIVER PROGRAM (CWP)

CHAPTER 1
ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

B.1.1 Intake Information/Referral

Responsible Office: Eligibility, Enrollment and Disenrollment
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
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
Definitions: Alabama Department of Mental Health Division of Developmental Disabilities (ADMH-DD); Call Center (CC); Home and Community Based Services (HCBS), Support Coordination Agency (SCA)- formerly referred to as Case Management Agency, Support Coordinator (SC)- formerly referred to as case manager, Division of Developmental Disabilities Information Management System (DDD IMS)
Procedures: Those seeking services for person with intellectual disabilities through the Alabama Department of Mental Health Division of Developmental Disabilities should:

1. Contact the Division of Developmental Disabilities Call Center at 1-800-361-4491.

2. The Call Center staff will complete the initial contact application on referrals for individual's three (3) years of age and up who meet the eligibility requirements and will request the Intellectual Quotient (IQ) (69 and below) of the person in need of services in addition to other pertinent information.

3. CC staff will accept calls from the individual requesting services, the legal guardian, the primary caregiver, or other interested parties who have consent to relay information and who will be responsible with assisting with the referral process.

4. Within two business days, an initial contact form will be sent via a note in DDD IMS to the local designated support coordination agency or other designated point of entry.

5. CC staff will make referrals to the SCA based solely on verbal report of the caller. CC staff will not deny 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. The Initial Contact Information Form will be sent to the SCA via the DDD IMS notes. This form will have the type of referral checked in the box at the top. There are three options; the first is the Initial Application Referral which reflects a first-time applicant requesting services. The second is Referral for Update which means there has been a call received from/for someone who already has been referred to the SCA but a Notice of Incomplete Application was sent to the requester. Third is the Info/Referral only which is used for persons looking for services outside of ADMH-DD. The same information sent to SCA is sent to the ADMH-DD Regional office Waiting List Coordinator. The eligibility determination process continues to be the prerequisite for all categories.

11. CC staff will send a letter to the person calling, verifying the date of call and that their requests have been forwarded to the designated SCA in their area to continue the application process.

12. CC staff will open a DDD IMS enrollment for the person in need of service. It is the responsibility of the SCA to make a change in DDD IMS reflective of the assigned support coordinator from the CC.

13. CC staff will send the application for services on referrals made by Department of Human Resources (DHR) on children or adults in their custody to the DHR, ADMH-DD contact, to the support coordination agency, to the Regional Community Services Director and the Community Services Waiting List Coordinator.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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:** 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.

*****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.

*Note: Initial Contact Information Form – *(See List of Forms Table)*

B.1.2 WAIT LIST

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

Responsible Office: Support Coordinator Services

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

Effective: October 1, 2021

Revised: March 22, 2022

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

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

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 and the 310 Board Agency of the new application via the DDD IMS;
    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 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 A.1.4) and the ICAP (reference ADMH-DDD OG A.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. A qualifying psychological evaluation(s) administered/interpreted by a qualified professional.
      - For an applicant eighteen years of age or older, two evaluations are required: one evaluation must be dated on or after the eighteenth birthday; and one evaluation must be dated prior to eighteenth birthday.
      - For a child applicant, this evaluation must be dated within three years of the date of application.
   b. An ICAP Compuscore report completed within ninety days of the date of a complete application packet.
   c. 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:
      i. 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.
      ii. The Diagnosis Record in ADIDIS (for Learning area)
   b. An ICAP Service Score of 85 or lower, as computed by the ICAP Compuscore.
   c. The applicant achieved a full-scale IQ score below 70, evidencing the presence of an intellectual disability, documented before the age of eighteen.
      i. For children, the IQ evaluation must be within three years prior to date of waiver application.
      ii. 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.
      iii. 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.d. may apply.
   d. 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.
6. 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 Waiting List for services if they scored below 480 in at least one of the

following ICAP domains: Social & Communication, Personal Living, Community Living, or Broad Independence.

7. 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.
8. In the event the needed additional information is not submitted within 60 days of the Waiting List Coordinator's DDD IMS notification, the application packet will be deemed incomplete, and the Waiting List Coordinator will send to the applicant a Notice of Incomplete Application (found in the Enrollments record in the DDD IMS). A copy of this notification will be recorded in the DDD IMS.
9. In the event the needed additional information is submitted within 60 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.
10. 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:
    e. All fields are completed fully and accurately.
    f. Confirm DDD IMS eligibility conclusion through accessing the Alabama Waiting List Application Report.
11. 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 <u>Approved</u>, thus placing them on the Waiting List.
12. 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.

B.1.2.b Wait List Selection Process

Responsible Office: System Management
Reference: ADMH Administrative Code 580-5-30-.14, 1.2.a Criteria for Determining Eligibility and Placement on the Waiting List, A.1.2.c Waiting List – Entry to Services
Effective: Historical Practice
Revised: April 7, 2023
Statement: A list of names will be selected periodically from the Statewide Wait List
Purpose/Intent: To ensure eligible individuals waiting for services are admitted periodically at time frames determined by the ADMH Central Office
HCBS Waivers: ID, LAH, CWP
Definitions: Central Office (CO); Mental Health (MH); Regional Office (RO)
Procedures: Upon notification to the CO MH Specialist II responsible for the submissions of applications to the Alabama Medicaid Agency (AMA), the CO MH Specialist II will select the number of individuals for the wait list as instructed by the CO Director of System Management and/or CWP Director by:

1. Running the report through the following process:
    a. At the System Home Screen choose the **ID Wait List**
    b. At ***Filters*** select work queue that is equal to "**Approved**"
    c. Select ***Tie-breaker date*** as the number instructed by the Director of System Management and/or CWP Director
    d. Select ***Status*** equal to "**Waiting, no services being provided**"
    e. Click ***Search*** and the report will be extracted
    f. Click on "**Alabama ID wait list ranking**" in blue print at the top of the page
    g. Export the data in desired program format
2. Save and Print the report.
3. Add information for persons pulled into the report to the Central Office Total Waiver Count spreadsheet.
4. The MH Specialist II will forward the list to the Director of System Management and/or the CSD.
5. The list will be sorted in ranking order showing those with the most critical need in the higher numbers as follows: **1**) 81-71, **2**) 70-61, **3**) 60-51,**4**)50-41, **5**)40-31, **6**) 30-21, **7**) 20-11, and **8**) 10-1.
6. The Director of System Management/CSD will use the following methodology to derive the total number of slots available at each RO by dividing the number of slots selected by the number of RO. (Example: 200 slots are selected and divided by the number of RO (5) totaling 40)
7. The MH Specialist II will send the wait list to all the RO Community Services Directors who will notify the RO Wait List Coordinator.
8. The CSD in each office will take the sum (40) and divide it by the number of ranks mentioned above (40/8=5) to select from each rank mentioned above to obtain the number of applicants from each rank 1-8 to pull equally.
9. If there are variances in the rank 1-8 based on applicant response, non-response or number waiting in each rank, the next person on the list in that ranking is chosen (Example: Region 1 has 2 persons selected from the list one in ranking 2 (70-61) and the other in 5 (40-31) who died before a slot became available. These two slots will be reallocated to the same rank 2 and 5 respectively until all ranking allocations are filled).

10. In the event that a rank has less than the number allocated, the slot should be moved to rank number 1.
11. The RO Wait List Coordinator verifies each individual's eligibility, as evidenced by a "Yes" answer to the applicable eligibility question (1915c waiver or 1115 Demonstration) within the Alabama Wait List Application Report in the individual's DD Information Management System record and verifies each individual's Medicaid eligibility status. [Re: ID/LAH Waiver OG A.1.2.a]
12. The RO Wait List Coordinator enters a note in the DD Information Management System that alerts the Support Coordinator as to action(s), if any, needed to begin the initial application process. [Re: ID/LAH Waiver OG A.1.2.c]
13. The RO Wait List Coordinator will notify the appropriate Support Coordination Agency and/or CWP Support Coordination Supervisor to begin the initial application process for those individuals identified for initial admission to the waiver within 60 business days.
14. The RO Wait List Coordinator will put the individual's case in "**pending**" status, in the DD Information Management System, to ensure the individual's name is not duplicated on the next wait list selection.
15. The CO MH Specialist II will monitor the initial applications and add the waiver enrollment dates for individuals processed, indicating the application was processed through the Alabama Medicaid Agency's Long-Term Care software.
16. The CO MH Specialist II will contact the RO Wait List Coordinator within 7 business day to determine the status of those applications not processed.
17. The CO MH Specialist II will report to the CO Director of Systems Management and/or CWP Director the number of individuals selected for each period and updates on the number of individuals whose applications have not been processed.
18. After all steps of the process have been followed, if the applicant has not been contacted, the Wait List Coordinator should follow the process outlined below as stated in the Associate Commissioner's Internal Executive Order dated June 8, 2022.
    a. Effective June 15, 2022, upon 60-day notification a waiver application is incomplete due to inability to make contact, the ADMH DDD Wait List Coordinator (WLC) will, as the FIRST ATTEMPT TO CONTACT, send notification of the individual's selection to enroll in an ADMH HCBS Medicaid Waiver by certified mail to the individual's last known address (AMA MSIQ address) and/or notify individual by personal visit to the individual's address of record.
    b. If contact is unsuccessful and/or no response within 30-days of attempted contact, as the SECOND ATTEMPT TO CONTACT, the ADMH DDD WLC will again attempt to contact the individual selected for waiver enrollment by certified mail to the individual's last known address (AMA MSIQ address) and/or by personal visit to the individual's address of record, informing them of their selection from the ADMH HCBS Waiver Wait List for enrollment into an ADMH HCBS Medicaid Waiver.
    c. If not successful and/or no response within 30-days of second attempt to contact, the WLC will notify the ADMH-DDD Associate Commissioner, who will complete the Waiver Enrollment - Waiting List 'Failure to Contact' letter notifying Alabama Disabilities Advocacy Program of the failed attempts by certified mail and/or personal visit to ADAP of the failed attempts and requesting assistance to contact the selected individual.

If ADAP is unsuccessful to contact and/or fails to notify ADMH DDD of their efforts within 45- days of receipt of notification, the individual will be 'skipped over for enrollment' and maintained on Waiting List to be identified as 'inactive'.

B.1.2.c Community Waiver Program Enrollment from the Waiting List

Responsible Office: Community Waiver Program

Reference: ADMH-DDD; Flowchart

Effective: December 17, 2021

Revised: January 12, 2022

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

Definitions: Interchange, PCP (Person-Centered Plan)

Procedures:

1. The Waiting List Coordinator:
    a. Sorts the Waiting List, via the DDD IMS, by county (according to identified pilot areas for the Community Waiver), including only those counties included in the pilot areas.
    b. Verifies statutory 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.
    c. If eligibility information is not current and/or available:
        i. the Wait List Coordinator will tag the 310 to provide missing and outdated information to include verification of contact information for the applicant.
        ii. 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.
    d. 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):
        i. They require services to preserve their current living arrangement (e.g., not seeking Residential services) and also 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.
        ii. 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.
        iii. They have a goal to obtain integrated, competitive employment or currently have integrated, competitive employment and require supports to maintain it.

e. 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.
f. 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.
g. If an individual that initially declined services reconsiders the Community Waiver Program, their Waiting List status will be updated at the point of contact.
h. 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.
i. 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 with the exception of 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. Completes a new RO Waiver Registration in the DDD IMS (reference Waiver Admission & Discharge OG).
    b. Adds the Support Coordination service to the Person-Centered Plan in the DDD IMS.
    c. Notifies, via the DDD IMS, the Regional Fiscal Manager of the enrollment for purposes of authorization of the Support Coordination service; and,
    d. Notifies, via the DDD IMS, the Central Office Waiver Coordinator of the enrollment and of the availability of the RO Waiver Registration and Interchange Screen.
    e. Once approval or denial is received from Central Office Waiver Coordinator, the RO Waiver Coordinator communicates with the appropriate Support Coordinator Agency

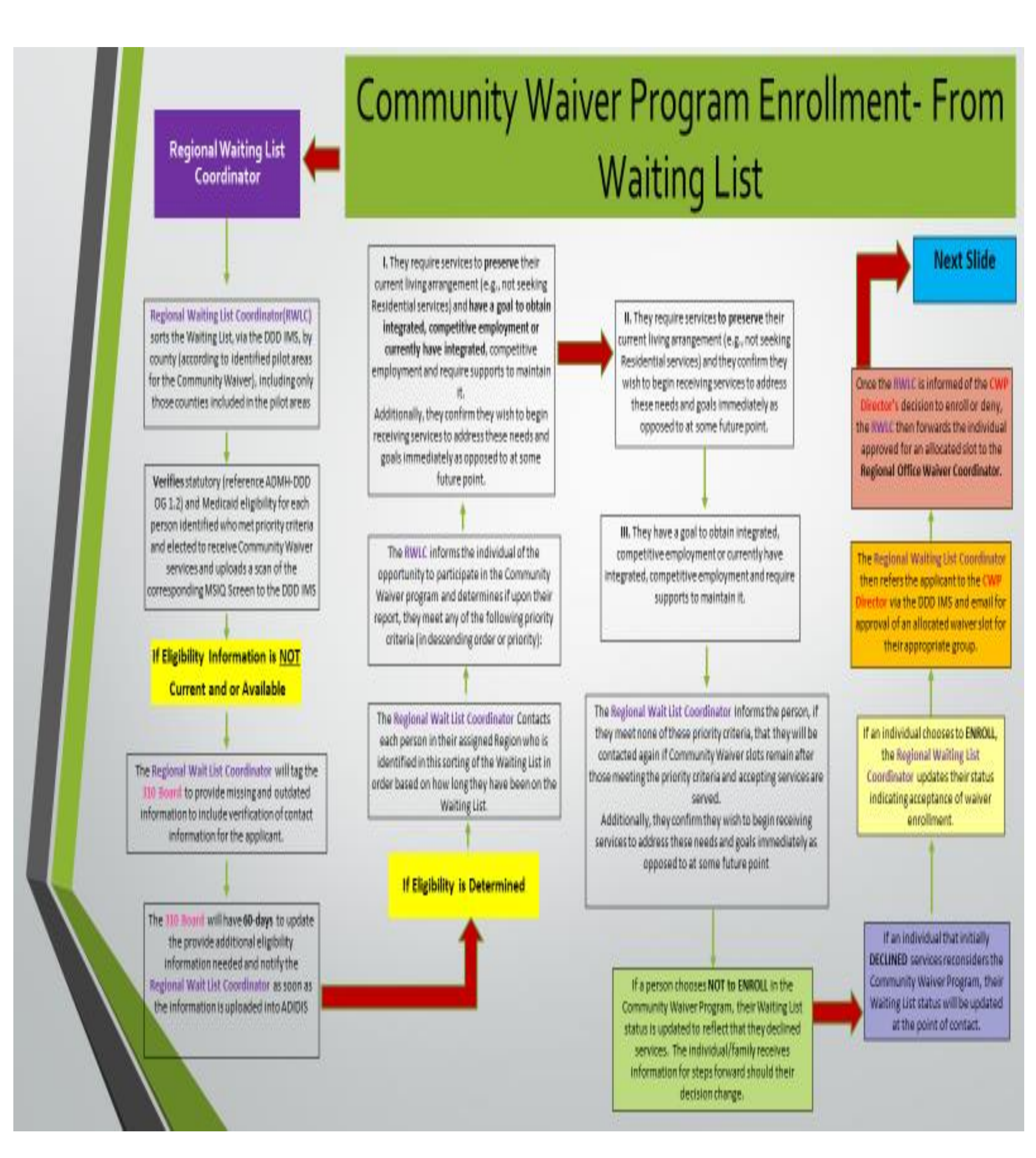
via DDD IMS (ADIDIS) of the decision.

f. 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 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.


Community Waiver Program Enrollment- From Waiting List
Regional Waiting List Coordinator
Regional Waiting List Coordinator(RWLC) sorts the Waiting List, via the DDD IMS, by county (according to identified pilot areas for the Community Waiver), including only those counties included in the pilot areas
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 MSIQ Screen to the DDD IMS
If Eligibility Information is NOT Current and or Available
The Regional Wait List Coordinator will tag the 310 Board to provide missing and outdated information to include verification of contact information for the applicant.
The 310 Board will have 60-days to update the provide additional eligibility information needed and notify the Regional Wait List Coordinator as soon as the information is uploaded into ADIDIS
If Eligibility is Determined
The Regional Wait 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 RWLC 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):
I. 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.
II. 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.
III. They have a goal to obtain integrated, competitive employment or currently have integrated, competitive employment and require supports to maintain it.
The Regional Wait List Coordinator 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
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.
If an individual that initially DECLINED services reconsiders the Community Waiver Program, their Waiting List status will be updated at the point of contact.
If an individual chooses to ENROLL, the Regional Waiting List Coordinator updates their status indicating acceptance of waiver enrollment.
The Regional Waiting 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 group.
Once the RWLC is informed of the CWP Director's decision to enroll or deny, the RWLC then forwards the individual approved for an allocated slot to the Regional Office Waiver Coordinator.
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Community Waiver Program Enrollment- From Waiting List
Start Here
If eligibility is determined and an allocated slot is available with the exception of financial requirements
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 Medicaid Form 204/205.
The 310 Board will request and obtain a completed Medicaid Form 376 from the RO Waiver Coordinator.
The 310 Board will directly submit both Medicaid Forms 204/205 and Form 376 to the appropriate District Medicaid office for approval or denial.
If Medicaid DENIES the individual information, the 310 will continue to assist the family until approval is granted.
If Medicaid APPROVES the 204/205 application, a 300% Waiver Slot is allocated for further enrollment into the CWP. Medicaid will notify the Sponsor and the RO Waiver Coordinator of approval or denial
The RO Coordinator will notify the Support Coordinator Agency of final decision on enrollment.
Regional Office Waiver Coordinator
(RO Waiver Coordinator)
Completes a new RO Waiver Registration in the DDD IMS (ADIDIS) (reference Waiver Admission & Discharge OG)
Adds the Support Coordination service to the Person-Centered Plan in the DDD IMS (ADIDIS)
Notifies, via the DDD IMS, the Regional Fiscal Manager of the enrollment for purposes of authorization of the Support Coordination service
Notifies, via the DDD IMS, the Central Office Waiver Coordinator of the enrollment and of the availability of the RO Waiver Registration and MSIQ Screen.
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 next steps
The RO Waiver Coordinator will send a formal written notification to the individual and attach the communication in ADIDIS.
Regional Fiscal Manager
Regional Fiscal Manager Authorizes, via the DDD IMS, the person enrolled for the Support Coordination service.
Central Office Waiver Coordinator
Forwards the RO Waiver Registration and MSIQ Screen to Medicaid for approval
The Central Office Waiver Coordinator notifies the RO Waiver Coordinator of the approval/denial
The Central Office Waiver Coordinator also notifies the CWP Support Coordinator Supervisor who assigns a Support Coordinator
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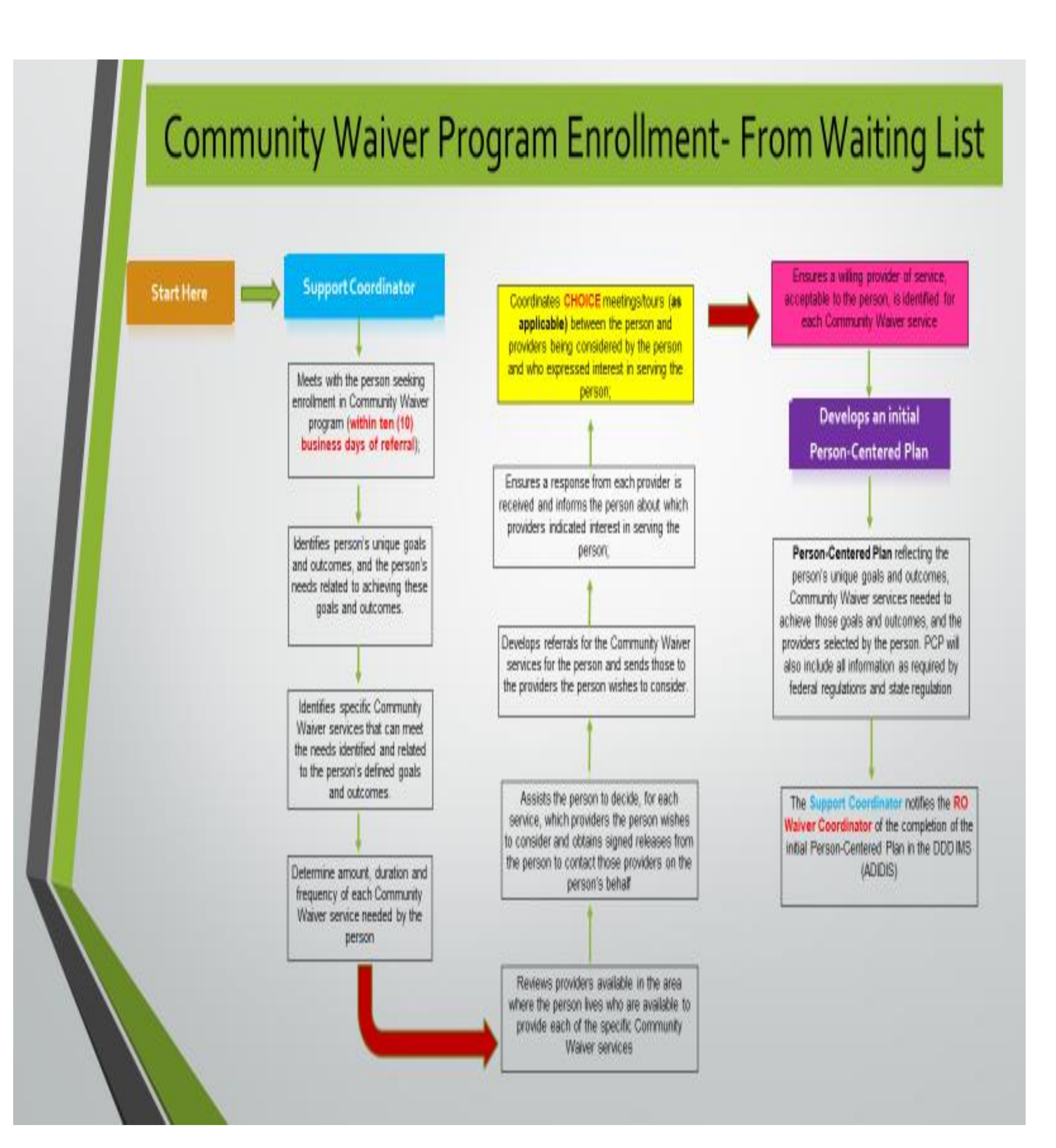

Community Waiver Program Enrollment- From Waiting List
Start Here
Support Coordinator
Meets with the person seeking enrollment in Community Waiver program (within ten (10) business days of referral);
Identifies person's unique goals and outcomes, and the person's needs related to achieving these goals 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
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
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;
Coordinates CHOICE meetings/tours (as applicable) between the person and providers being considered by the person and who expressed interest in serving the person;
Ensures a willing provider of service, acceptable to the person, is identified for each Community Waiver service
Develops an initial Person-Centered Plan
Person-Centered Plan 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. PCP will also include all information as required by federal regulations and state regulation
The Support Coordinator notifies the RO Waiver Coordinator of the completion of the initial Person-Centered Plan in the DDD IMS (ADIDIS)

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

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

Definitions: CWP (Community Waiver Program); DDD (Division of Developmental Disabilities; PCP (Person Centered Plan); RFA (Request for Action) CWP/SRT (Community Waiver Program/Special Review Team)

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

      Specifically, the CWP/SRT shall:

      i. Approve or deny enrollment using the Group #4 Needs Verification Scoring Tool attached.
      ii. 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.
      iii. 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

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

Definitions: CWP (Community Waiver Program); DDD (Division of Developmental Disabilities; PCP (Person Centered Plan); RFA (Request for Action) CWP/SRT (Community Waiver Program/Special Review Team) Reserved Capacity Slots are defined as Outplacement from Nursing Homes of Other Institutional /setting, Transition from LAH Waiver, Children in State Care/Custody and Emergencies.

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:
    i. 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.

ii. 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.

iii. 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.

iv. 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:

    i. 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.

    ii. 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.

    iii. 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.

    iv. 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.

a. 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.
b. 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:

c. Approve, approve with modifications, or deny enrollment in CWP using the attached form.
d. If approved, the respective CWP Support Coordinator Supervisor and Wait List Coordinator shall be notified and instructed to enroll individual.
e. If denied, the respective CWP Support Coordinator Supervisor and Wait List Coordinator shall be notified and instructed to maintain individual on the waiting list.
f. 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
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
Definitions: CWP (Community Waiver Program); ICAP (Inventory for Client & Agency Planning)
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: 0 (No Support) 1 (Monitoring; Occasional Assistance) 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)	
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

Responsible Office: Community Waiver Program

Effective: December 17, 2021

Revised: June 17, 2022

Statement: A waiting list strategy will be utilized in the event slot capacity is reached for either the Community Waiver Program 1915(c) waiver or the 1115 Group 5.

Purpose/Intent: Persons on the Waiting Lists will be enrolled for CWP services in a systematic manner, based on enrollment priorities and application dates.

HCBS Waivers: CWP

Definitions: 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); Person-Centered Plan (PCP)

Procedures:

1. In the event that slot capacity is reached for the Community Waiver Program (CWP), either the 1915(c) waiver or the 1115 Group #5, applicants will be placed on the corresponding Waiting List for services via the DDD Information Management System (IMS).
   a. This requires completion of a Criticality Assessment, as per DDD OG A.1.4 Criticality Assessment.
2. As open and applicable slots for the CWP become available, those applicants on the Waiting List in each Pilot Area will be selected to receive services based on length of time on the Waiting List and the specified enrollment priority criteria.
   a. Applicants on the Waiting List in each Pilot Area will be rank ordered according to the date they applied for waiver services, from earliest date to most recent. Using this list, applicants will be contacted in order from those with earliest date to most recent. Applicants will be further prioritized based on the following criteria, as confirmed through contact and assessment by the Regional Community Services (RCS) Waiting List Coordinator:
      i. Enrollment Priority Category # 1: Commitment to preserve the current family/independent living situation AND if aged 22-64, commitment to obtain/maintain competitive integrated employment.
      ii. Enrollment Priority Category # 2: Ages 22-64 with commitment to preserve the current family/independent living situation but no commitment to obtain/maintain competitive integrated employment.
      iii. Enrollment Priority Category # 3: Commitment to obtain/maintain competitive integrated employment.
      iv. Enrollment Priority Category # 4: Meets none of the above enrollment priority categories.
3. Applicants on the Waiting List contacted, and who meet the criteria for Enrollment Priority Category #1 will be offered enrollment. Others will have their Enrollment Priority Category noted for follow-up contact should open slots remain. In that event, individuals in Enrollment Priority Category #2 will be contacted again in order, by length of time on Waiting List, and offered enrollment until all available slots are filled. If slots remain after this, Category #3 will be

contacted again in order, by length of time on Waiting List, and offered enrollment until all available slots are filled.

If slots remain after this, Category #4 will be contacted again in order, by length of time on Waiting List and offered enrollment until all available slots are filled.

4. If any slots remain in a particular CWP region after the process described above is fully implemented, the slots will be available for reassignment. *See O.G. B.6.1 Community Waiver Program Slot Reallocation Process.*

5. As the Waiting List Coordinator identifies applicants to enter services, the Waiting List Coordinator:
    a. Verifies statutory 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.
        i. In the event Alabama Medicaid eligibility status is in Delete status or has inconsistent eligibilities for the current year, or the applicant is enrolled in another Waiver program, the Waiting List Coordinator will, within two (2) business days, notify the RCS Support Coordinator, who will contact the person/family and assist with the Medicaid application process in order to address the eligibility issue(s) identified.
        ii. Completes a new RO Waiver Registration in the DDD IMS (reference Waiver Admission & Discharge OG A.1.6.b).
        iii. Adds the Support Coordination services to the Person-Centered Plan (last page) in the DDD IMS.
        iv. Notifies, via the DDD IMS, the Regional Fiscal Manager of the enrollment for purposes of authorization of the Support Coordination service; and,
        v. Notifies, via the DDD IMS, the Central Office Waiver Coordinator of the enrollment and the availability of the RO Waiver Registration and Interchange Screen.
        vi. Notifies, via the DDD IMS, the CWP Support Coordination Supervisor for the appropriate region.
6. The Regional Fiscal Manager:
    a. Authorizes, via the DDD IMS, the person enrolled for the Support Coordination service.
7. The Mental Health Specialist II:
    a. Forwards the RO Waiver Registration and Interchange Screen to Alabama Medicaid for approval.

B.1.4 Inventory for Client and Agency Planning (ICAP) for Community Services

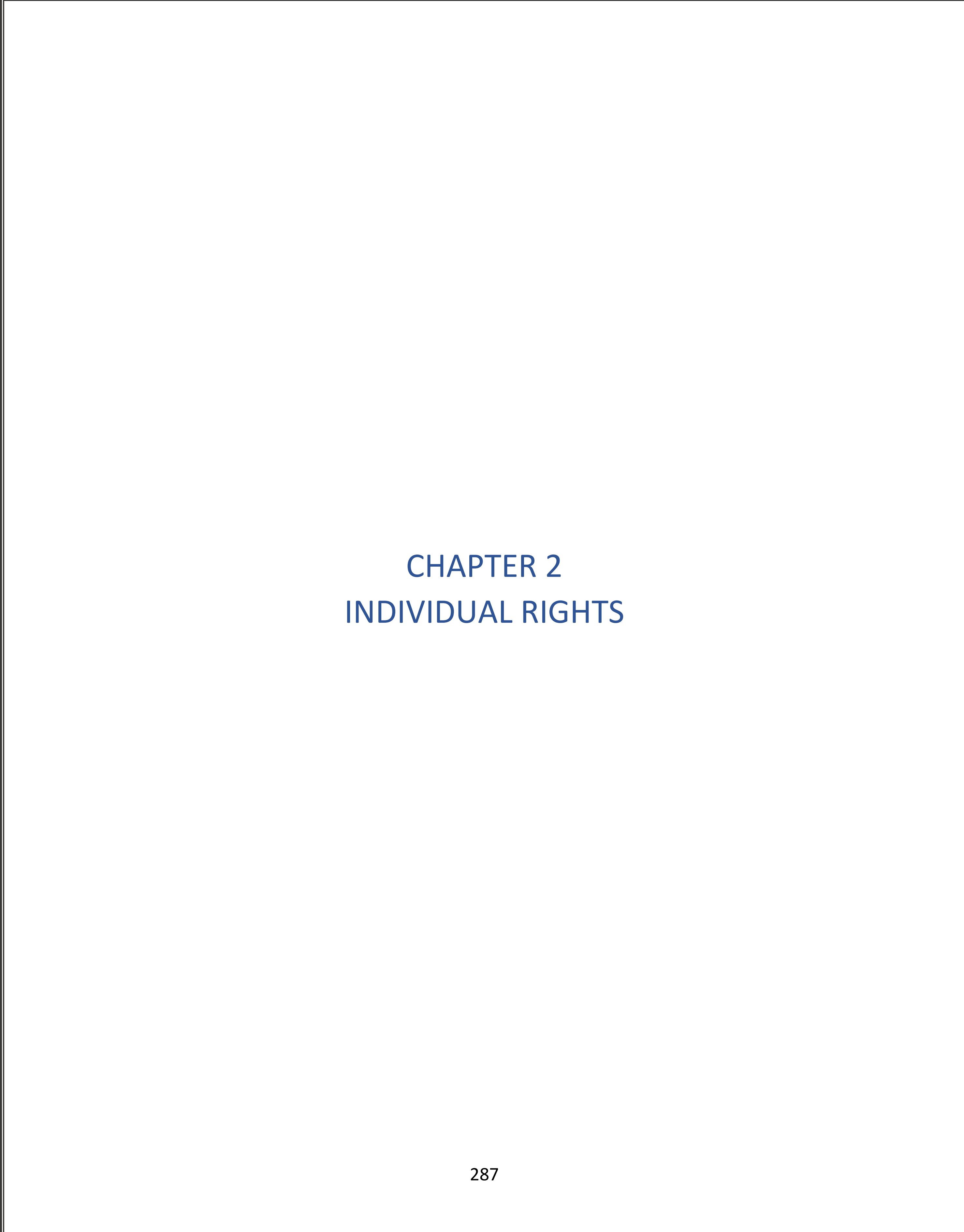
Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30.14 Eligibility and Level of Care Determinations for Medicaid Waiver Programs
Effective: Historical Practice
Revised: April 13, 2023
Statement: The ICAP is administered by the Support Coordinator to assess adaptive 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
Definitions: ICAP (Inventory for Client and Agency Planning); RCS (Regional Community Services); CSS (Comprehensive Support Services)
Procedures:

1. Prior to administering the ICAP, the Support Coordinator will be trained 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
        i. 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:
        i. Client information
        ii. Section A. Descriptive Information
        iii. Section B. Diagnostic Status
        iv. Section C. Functional Limitations and Needed Assistance

v. 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.



CHAPTER 2
INDIVIDUAL RIGHTS

B.2.1 Appeals Process for Adverse Actions – Services

Responsible Office: Individual Rights

Reference: 42-CFR 431.210 (Subpart E)

Effective: December 30, 2021

Revised: July 28, 2022

Statement: ADMH/DD Division provides an opportunity to request an appeal through an Informal Conference and/or a Medicaid Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are denied service(s), choice of provider(s), or whose services are(b) suspended, reduced, terminated, or delayed. ADMH/DD Division provides Notice of Appeal Rights Adverse Action as required in 42 CFR §431 .210.

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

HCBS Waivers: ID/LAH/CWP

Definitions: Informal Conference – the informal conference is an opportunity for the individual and/or representative to have the adverse action reviewed by the ADMH-DDD for decision and resolution; RFA (Request for Action – the form used to describe request (e.g., service, purchase, provider), CSD (Community Services Director)

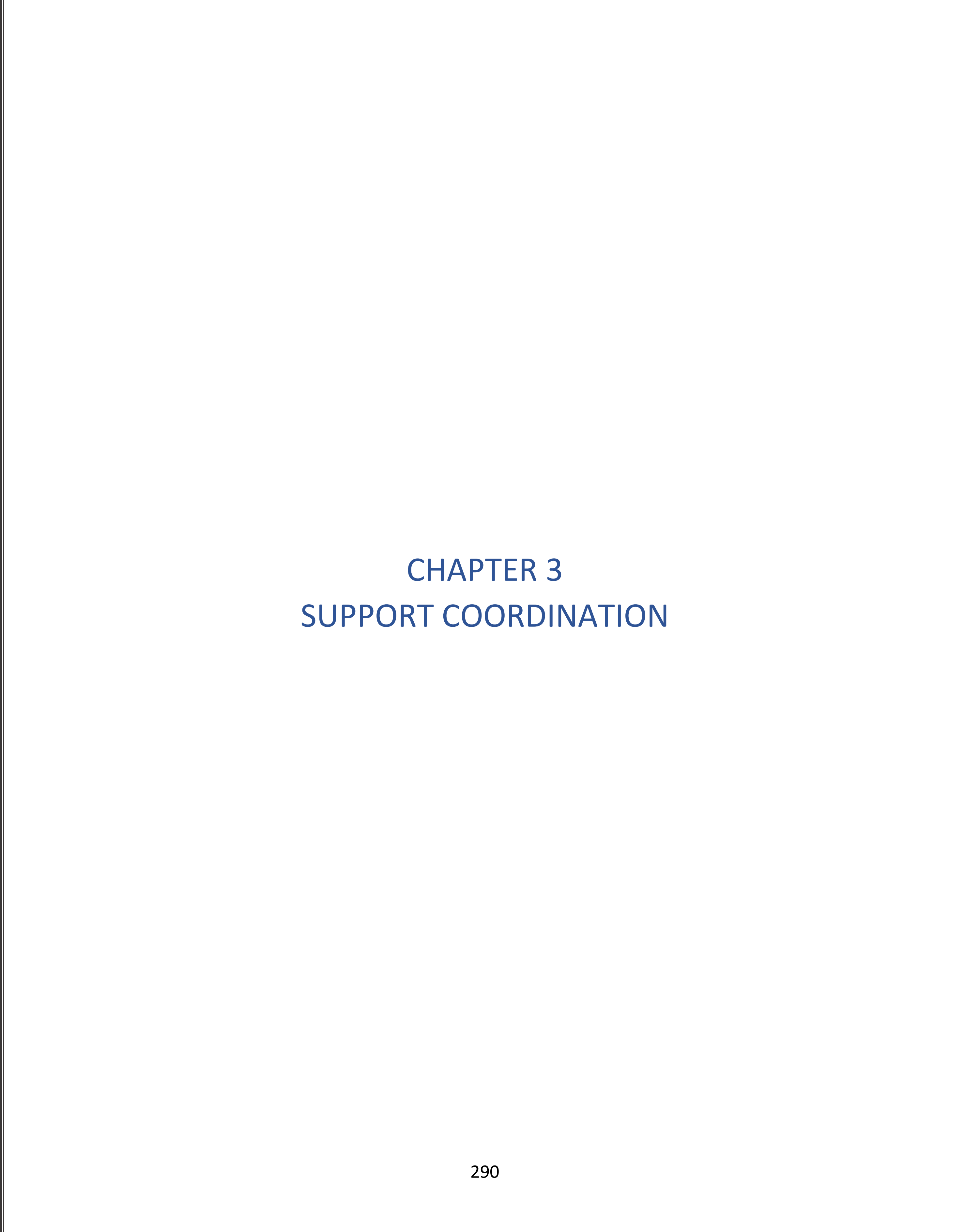
Procedures:

The DD Division will adhere to the following procedures for appropriate notification of adverse action taken by the regional office, the steps to appeal through Informal Conference and the process for decision making and resolution:

6. Written advanced notification to the individual or responsible person must include:
    a. Date of Notice
    b. The specific adverse action being taken
    c. Specific information about the reason(s) for the adverse action
    d. The effective date of the action
    e. The individual's right to request an informal conference at ADMH-DDD and/or a fair hearing with Alabama Medicaid and the procedures for doing so following established procedures
    f. An ADMH-DDD informal conference is not an alternative to a Medicaid fair hearing.
    g. Services involved will continue at the current level according to the Person-Centered Plan (PCP) until the appeal process has been exhausted. Services requested, denied and/or not currently on the PCP will not be provided during the appeal process
    h. Point of contact if there are questions regarding the action
    i. **NOTE**: If denial relates to (b) services that are denied, suspended, reduced, or terminated, DMH must issue a written notice at least 10 days prior to the action to the individual, and/or representative indicating their right to appeal.
7. To appeal, the individual must send a written request along with the Notice of Appeals Rights Adverse Action form no later than 15 calendar days after the effective date printed on the Notice to the Division's Office of Appeals and Constituent Affairs at the ADMH street address indicated on the Notice of Appeal Rights Adverse Action form. The Appeals Coordinator will choose a panel of three members to review the denied RFA.
8. Review Panel:
    a. The review panel 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.

b. The panel will review the denied RFA and other information individually making note of any questions that may arise and complete the Initial Review of Denial Form.

9. Teleconference:
   a. A teleconference, if needed, will be scheduled with the 1) individual and as appropriate, the individual's representative (ex., family, guardian, authorized representative), 2) panel participants, 3) Staff (CSD or CWP Director) responsible for denying the RFA, 4) Individual's Support coordinator AMA Waiver Program Manager.
   b. The teleconference will provide the individual and their representative the opportunity to offer supporting information as part of the review. The panel will also utilize the time to ask any specific questions to the staff, individual and/or their representative, or the panel that may be needed to provide more clarity.
10. Decision Making and Notification:
   a. Following the teleconference, the panel will complete the Review of Denial Form indicating reasons for their decision
   b. The panel will then meet to reach agreement on the final informal conference decision to either reverse or uphold the original decision
   c. The panel will select a panel participant who will 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:
      i. Description of initial request that warranted a denial
      ii. Action(s) taken to review the appeal
      iii. Final informal conference decision (denial upheld or reversed) and supporting reason (resource or other information to support decision)
      iv. Effective date of decision (if appropriate)
      v. 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.
   f. The Appeals Coordinator will then 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, CSD, the ID/LAH/CWP Waiver Director, the Regional Office Fiscal Manager, and others as appropriate.



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
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
Definitions: ADMH (Alabama Department of Mental Health); AMA (Alabama Medicaid Agency); CWP (Community Waiver Program); DDD (Division of Developmental Disabilities);
PCP (Person Centered Plan); AMA (Alabama Medicaid Agency)
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

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

Definitions: 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.
6. **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

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

Definitions: Request for Regional Action (RFA)

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:

Reason for RFA	Support Coordinator Submits RFA To:	Recipient of RFA Action/Timeline:
Exceed Unit Cap for Specific Service	CWP Director *(And or designee)*	Review RFA and supporting documentation. Render decision within 5 business days of receiving RFA.
Exceed Expenditure Cap	CWP Director *(And or designee)*	Review RFA and supporting documentation. Do additional information-gathering as needed to arrive at recommendation to be sent to CWP Director for decision rendering within 15 business days of receiving RFA.
Request to Transition to Different CWP Enrollment Group	CWP Director *(And or designee)*	Review RFA and supporting documentation. Do additional information-gathering as needed to arrive at recommendation to be sent to CWP Director for decision rendering within 15 business days of receiving RFA.
Request for Breaks and Opportunities and/or Positive Behavior Supports	CWP Director *(And or designee)*	Follow Emergency Need for Respite and/or Crisis Positive Behavioral Supports. Review RFA and supporting documentation and render decision within 2 business days of receiving RFA.
Skilled Nursing Authorization	Regional Office Nurse	Review RFA and supporting documentation. Submit to Regional Office RN within 3 business days of receiving RFA for additional information gathering and assessment and rendering decision within 26 business days.
CSS Consultation	Director of Psychological Services *(And or designee)*	Decision within 5 business day of receiving the processed RFA from the Regional Community Services Specialist IV (RO Evaluator).
CSST Consultation (Crisis referral)	Director of Psychological Services	Review RFA and supporting documentation. Act on RFA within 1 business day of receiving RFA and initiate CSST consultation within 2 business days of receiving RFA.

- RFA’s sent to CWP Director: The CWP Director will forward the RFA, supporting documentation and recommendation from the Support Coordination Supervisor to the Associate Commissioner within 2 business days of receiving it. Within 7 business days of the CWP Director receiving the RFA and after meeting with division leadership for review, a decision will be made. 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.

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

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

Definitions: RCS (Regional Community Services); ID Waiver (Intellectual Disabilities Waiver); LAH Waiver (Living at Home Waiver); ADRS (Alabama Department of Rehabilitative Services); CWP (Community Waiver Program); IMS (Information Management System); IPE (Individualized Plan for Employment)

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.
        i. 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.
        ii. 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.
        i. 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.

    ii. 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.

Note: Request for Action Form

B.3.5 Individual Experience Assessment (IEA)

B.3.5.a Initial - IEA

Responsible Office: Community Waiver Program

Reference: 2014 HCBS Rule

Effective: January 12, 2022

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

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

HCBS Waivers: CWP

Definitions: People - HCBS Waiver participants; 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 timeframe.
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 CWP Planning & Quality Assurance Specialist within at least TEN (10) business days of the date the survey was completed. [Original to the CWP Planning & Quality Assurance Specialist, 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 survey. Follow up may consist of revision of the PCP by the Support Coordinator or remediation by the provider with completion verified by the CWP Planning & Quality Assurance Specialist 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 surveys (original) should be forwarded to the CWP Planning & Quality Assurance Specialists and Support Coordination Supervisors. 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

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

Definitions: 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 <u>in a setting that the provider ***did not*** previously use for ID/LAH waivers</u> (i.e., a ***new*** setting):

   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 is ***new***), the SC must administer the first IEA within 5 days (before or after) the 60th day the person is receiving services in the ***new*** setting. After that, the IEA is administered annually as described in #1 above.

3. <u>**VERY IMPORTANT:**</u> 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. Any issues identified by the Support Coordinator must be immediately shared with CWP P&Q Staff via note in the DDD Information Management System (ADIDIS). The CWP QE Staff will require a corrective action plan (in CWP, this is called a "Plan of Alignment" for compliance) that will be approved and monitored by QE Staff for completion within 90 days.

4. The IEA form that must be used 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.

5. Completed IEA forms must be stored in ADIDIS by the SC in the Assessment Tab by selecting ***Save and Close Assessment.***

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

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

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

Procedures:

1. The Support Coordinator:
    a. Completes supporting documentation uploaded to the DDD IMS Notes tab:
        i. Signed Person-Centered Plan
        ii. Comprehensive Person-Centered Assessment Documentation and Planning
        iii. CWP - Freedom of Choice
        iv. 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.

        v. Updated ICAP
        vi. Psychological Evaluation (which documents presence of intellectual disability)
        vii. 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:
        i. Demographics
        ii. Diagnosis
        iii. Eligibility
        iv. Employment Status
        v. 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

i. Signed Person-Centered Plan updated within the past year.

ii. Comprehensive Person-Centered Assessment Documentation and Planning updated within the past year.

iii. Physical or RN Assessment (if necessary, only until physical is obtained).

iv. 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

v. Psychological Evaluation (which documents presence of intellectual disability – IQ under 70)

vi. An Individual and Family History updated within 90 days of re-evaluation.

c. Prints the Level of Care (LOC) form from the Demographics tab.

i. For CWP 1915c Groups #1 -#4: Ensures eligibility is evidenced by at least 3 areas of life activity checked on the LOC.

ii. 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]:

i. Opens the **Diagnosis tab** to ensure information there is consistent with the IQ level on the Level of Care (LOC).

ii. Reviews the Eligibility Assessment under the **Assessments tab** (Psychological/ICAP/ABS).

(1) Ensures it was completed within 60 days of the redetermination date.

iii. Ensures the referenced IQ score is less than 70.

iv. Ensures the referenced ICAP was completed within 2 years and updated at least annually.

v. Ensures the referenced ICAP score meets eligibility requirements:

(1) For CWP 1915c Enrollment Groups #1 to #4, ICAP score of 85 or lower is required for eligibility

(2) For CWP 1115 Enrollment Group #5, ICAP showing at least one domain score of 480 or lower for eligibility

vii. 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.

viii. 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:
        i. RO Waiver Registration
        ii. 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.
8. The Regional Administrative Assistant:
    a. Prints the LTC-2.
    b. Files the RO Waiver Registration, Interchange Screen, LOC, and LTC-2.
9. If the ICAP score has changed from previous administration, the waiver coordinator will notify the Fiscal Manager.

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:

Definitions: CWP (Community Waiver Program); Person-Centered Plan (PCP); RCS (Regional Community Services); MOA (Memorandum of Agreement); Request for Provider (RFP); BSP (Behavior Support Plan))

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 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 person and supporting the person's communication with others
   j. How person is best supported (what works/what doesn't work)
   k. How 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 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.

B.3.8 Comprehensive Support Services (CSS) Teams

Responsible Office: Behavioral Services

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

Effective: September 8, 2022

Revised: April 1, 2023

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: CWP

Definitions: CSS Teams support persons enrolled in ID, LAH or CWP waiver programs; and
who are experiencing behavioral challenges which require diagnostic or treatment consultation after interventions have been attempted without consistent positive outcome; and
whose experienced behavioral challenges are significant, including crisis, and/or emergency situations that may lead to an individual experiencing psychiatric hospital admission, incarceration, or challenges to maintaining community living.

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 currently located in Decatur, Tuscaloosa, Montgomery, and Mobile, within ADMH-DDD Regional Community Services offices. The teams offer state-wide coverage.
4. Consultation Services Provided:
    a. **Training**- Staff, agency, support persons trainings 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:

   i. Persons with ID who are receiving HCBS Waiver program services and are exhibiting challenging behaviors with the potential to escalate into a near-term 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.

   ii. Those for whom medical, psychiatric, or dental services cannot be obtained in the community for a person otherwise eligible for services provided by CSS Teams

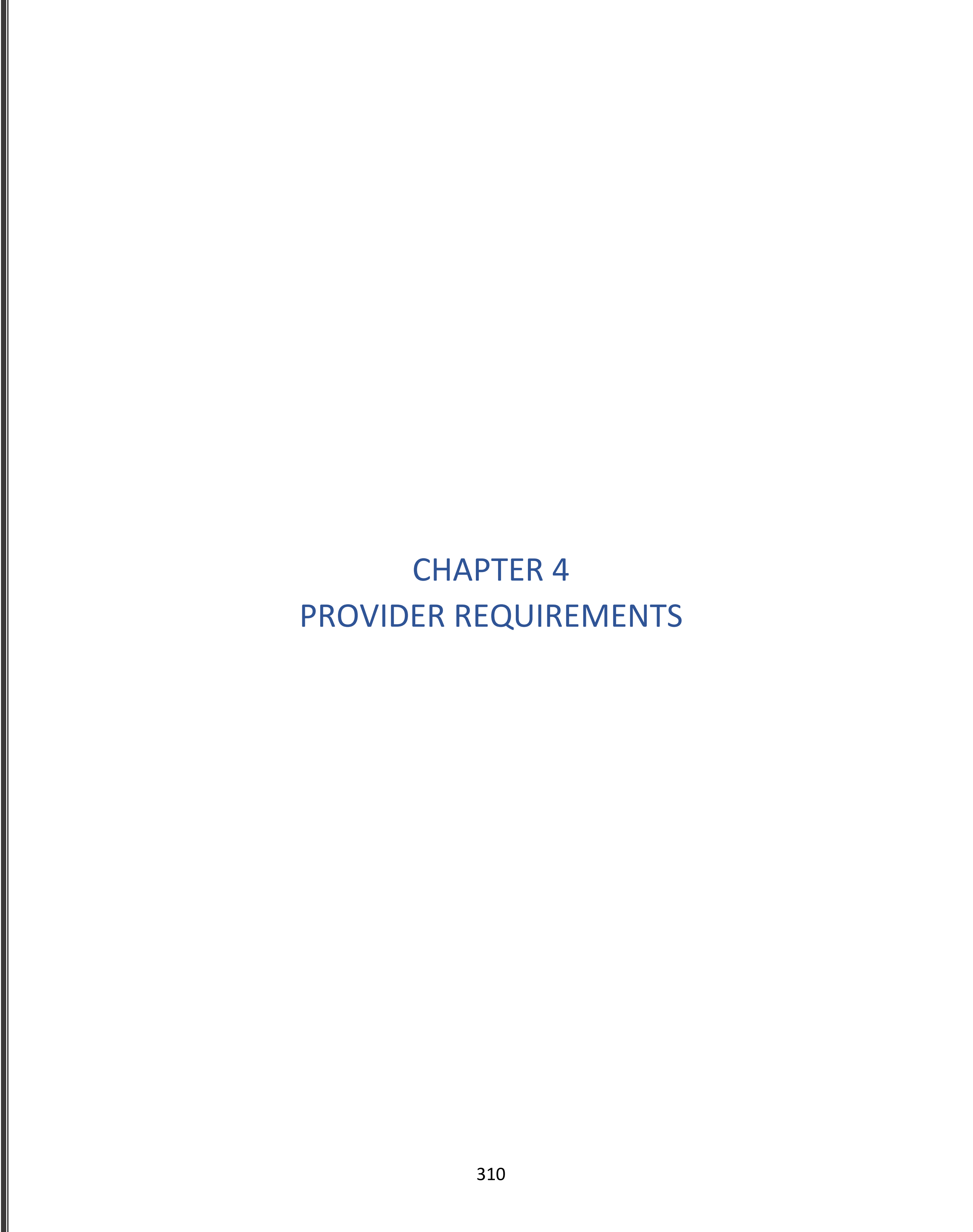
   iii. Those for whom current behavioral or medical/dental treatment strategies are not effective for a person otherwise eligible for services provided by CSS Teams

   iv. Persons who have numerous psychotropic medications or high doses prescribed

   v. 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

   vi. Involvement with law enforcement due to challenging behaviors

5. 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 to be 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, contact information is listed here: https://mh.alabama.gov/division-of-developmental-disabilities/psychological-and-behavioral-services/ .



CHAPTER 4
PROVIDER REQUIREMENTS

B.4.1 Provider Personnel Qualifications and Training Requirements

Responsible Office: Community Waiver Program

Effective: July 28, 2022

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

Definitions: QuILTSS: The online learning management systems that houses many CWP required trainings; Direct Support Personnel (DSP)

Procedures:

A. 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.**"*

1. 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 (QuILTSS Module)
(2) Orientation (QuILTSS Module)
(3) Introduction to CWP (QuILTSS Module)
(4) Supporting People with IDD (QuILTSS Module)
(5) Keys to Independence: Everyone Can Succeed (QuILTSS Module)
(6) Supporting Community Participation (QuILTSS Module)
(7) Standard Precautions (QuITLSS Module)
(8) Signs and Symptoms of Illness/Medication Side Effects (QuILTSS 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 (QuILTSS Module)
(2) The Importance of Full Citizenship and Valued Social Roles (QuILTSS Module)
(3) Supporting People to Form and Keep Relationships (QuILTSS Module)
(4) The Importance of Employment (QuILTSS Module)
(5) Emergency Preparedness (QuILTSS Module)
(6) Working with Person Supported, Families/Conservators (QuILTSS Module)
(7) Supporting Self-Determination (QuILTSS Module)

c) Upon completion of courses listed in #A2b, the following courses should be completed:

(1) Positive Behavior Supports (QuILTSS Module)
(2) What Really Keeps People with IDD Safe (QuILTSS Module)
(3) Home and Community Based Services (QuILTSS Module)

B. Additional Agency Direct Service Personnel Qualifications and Training Requirements Applying to Specific Services that <u>Must Also</u> Meet Standard Minimum Qualifications and Training Requirements Noted Above:

1. <u>Employment Supports-Individual Employment Supports:</u>

a) Provider Agency Qualifications:

(1) 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

(1) 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.

(2) 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).

2. Employment Supports-Small Group Supports:

a) Provider Agency Qualifications

(1) 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

(1) 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).

3. 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.

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).

4. 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 QuILTSS 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.

5. 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 QuILTSS 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.

6. Support Coordination

a) Must complete the following training:

(1) Welcome to Employment & Community First (QuILTSS Module)

(2) Orientation (QuILTSS Module)

(3) Introduction to CWP (QuILTSS Module) (Add)

(4) Supporting People with IDD (QuILTSS Module)

(5) Keys to Independence: Everyone Can Succeed (QuILTSS Module)

(6) Supporting Community Participation (QuILTSS Module)

(7) Standard Precautions (QuILTSS Module)

(8) Disability Rights Movement (QuILTSS Module)

(9) The Importance of Full Citizenship and Valued Social Roles (QuILTSS Module)

(10) Supporting People to Form and Keep Relationships (QuILTSS Module)

(11) The Importance of Employment (QuILTSS Module)

(12) Working with Person Supported, Families/Conservators (QuILTSS Module)

(13) Supporting Self-Determination (QuILTSS Module)

(14) Positive Behavior Supports (QuILTSS Module)

(15) What Really Keeps People with IDD Safe (QuILTSS Module)

(16) Home and Community Based Services (QuILTSS Module)

(17) Person-Centered Planning

(18) Alabama Department of Mental Health ADIDIS Training

(19) THERAP Training

(20) Serious Incident Prevention Management System Training

(21) Medicaid Home and Community-Based (HCBS) Settings Rule HCBS Modification

(22) Community Waiver Program Overview Training

(23) Inventory for Client and Agency Planning (ICAP) Training

(24) Self-Directed Services

(25) Medicaid Enrollment/Reinstatement

(26) Support Coordinator Relias Training

(27) CWP Documentation Training

C. 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
   a) Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   b) 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:
      (1) Directing the person-centered planning (PCP) process;
      (2) Understanding and considering self-direction;
      (3) Understanding and considering individualized integrated employment/self-employment;
      (4) Understanding and considering independent and supported living community living options.
   c) Prior to service delivery, must complete training addressing the following topics:
      (1) Disability Rights Movement (QuILTSS Module or with content preapproved by ADMH/DDD)
      (2) 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)
      (3) 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

d) 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.
e) 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
   a) Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   b) Prior to service delivery, must complete training addressing the following topics:
      (1) 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)
      (2) Training specific to the individual(s) being served, including training on their person-centered plan and specific reasons for referral for the service
   c) 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.

   d) Complete no less than two (2) hours of annual refresher training.

3. Financial Literacy and Work Incentives Benefits Counseling
   a) Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
   b) Minimum of Associates Degree in human service or related field.
   c) For Work Incentives Benefits Counseling: Must be a certified Community Work Incentives Coordinator (CWIC) or Work Incentives Practitioner (WIP).
   d) Prior to service delivery, must complete training addressing the following topics:
      (1) 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)
      (2) Training specific to the individual(s) being served, including training on their person-centered plan and specific reasons for referral for the service

   e) 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.
   f) 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
   a) Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.

b) 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).
c) 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.
d) Has completed DDD training in positive behavior supports and/or behavioral psychology.

5. Physical Therapy
a) Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
b) Physical Therapists employed or contracted by provider organization are licensed under the Code of Alabama, 1975 Sec.34-24-212.

6. Occupational Therapy
a) Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
b) 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
a) Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
b) 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
a) Must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
b) Prior to service delivery, must complete training addressing the following topics:
    (1) 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)
    (2) Training specific to the individual(s) being served, including training on their person-centered plan and specific reasons for referral for the service

c) 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
a) Nurses are licensed under the Code of Alabama; 1975 Sec. 34-21.

10. Community Transportation
    a) 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
    a) 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.
    b) 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:
    a) Must meet all applicable state (Alabama Code 230-X-1) and local licensure requirements.
    b) Must meet all construction, wiring, and/or plumbing building codes, as applicable.

13. Assistive Technology and Adaptive Aids
    a) Must meet all applicable state (Alabama Board of Home Medical Equipment Services Providers) and local licensure requirements.

D. Standard Self-Directed Services Direct Service Personnel Qualifications

1. Prior to hire, must pass a statewide background check confirming no convictions for any crime of violence, abuse, neglect, exploitation, or any felony offense.
2. 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:
    a) Personal Assistance – Home (including family providers)
    b) Personal Assistance – Community
    c) Breaks & Opportunities (Respite)
    d) Community Transportation
    e) Community Integration Connections and Skills Training
    f) Independent Living Skills Training
3. 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:
    a) 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.

b) 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.

4. **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 Provided in the Provider's Contract

Responsible Office: Community Waiver Program

Effective: December 5, 2022

Revised: June 17, 2022

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

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.
2. **If the provider is seeking to add a service(s),** the updated CWP Application must include an attachment <u>for each new service the provider is seeking to add</u>, 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 <u>for each service the provider is seeking to delete</u>, 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: Support Coordination (Case Management)
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
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
Definitions:
1. 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.

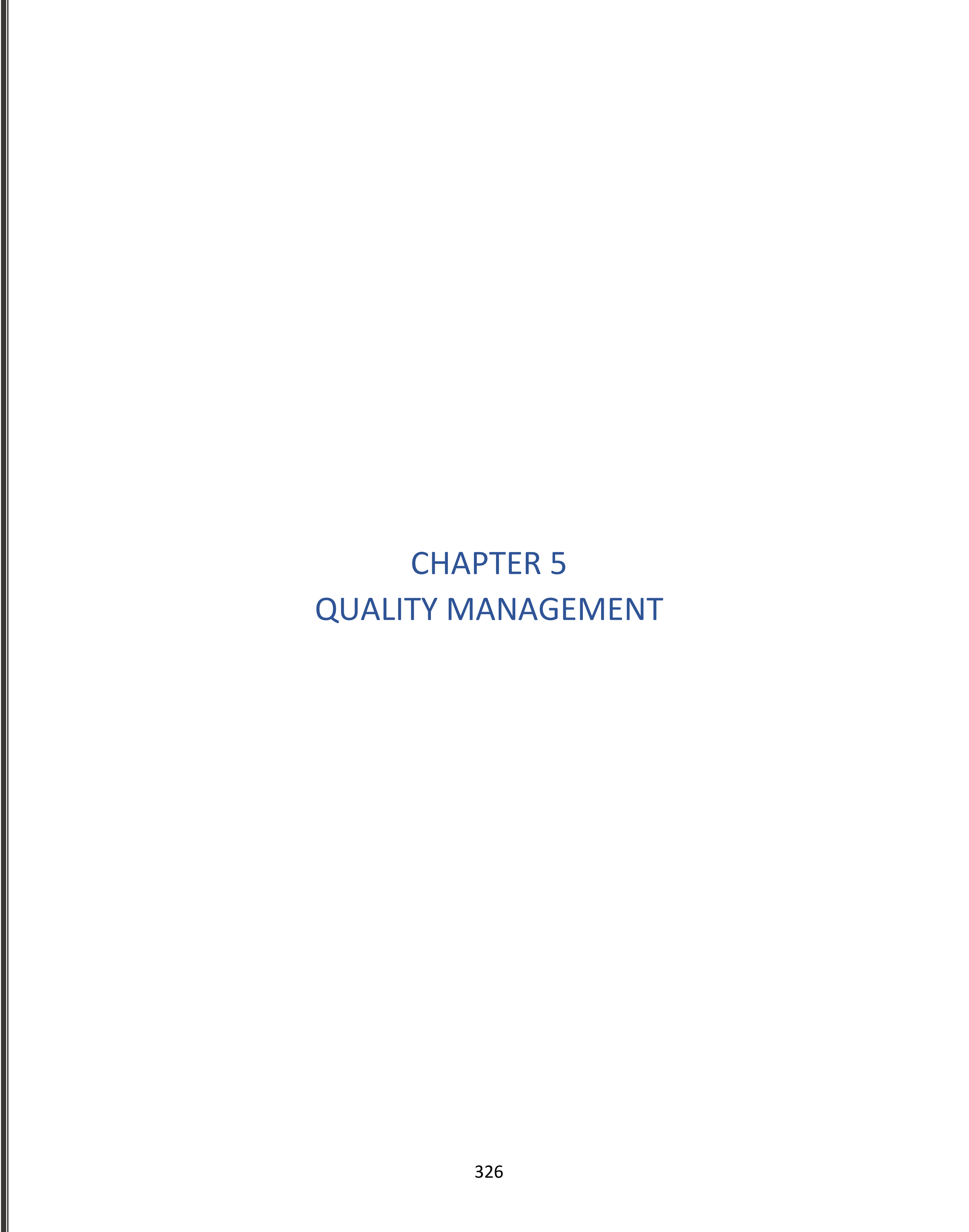
2. Residency Agreement: The document that evidences the complete terms under which parties have agreed as attested by their signature.
3. Room and Board: The cost for the provision of meals, a unit or room to sleep, laundry, basic utilities, housekeeping, pest control, maintenance, insurance, etc., which reflects a proportional allocation of which are shared expenses with other residents/tenants in the same home.
4. Residential Home: The provider owned, and controlled setting chosen by the individual to receive HCBS Waiver services.
5. Provider: The owner and operator of the residential home.
6. 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.
7. Legal representative: The individual's/tenant's court ordered legal representative that must sign along with or on behalf of the Individual.
8. 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.
9. Appeals Process for Adverse Actions – Service Decision and Informal Conference – Services: The operational guidelines to address actions that may negatively impact the waiver participant.
10. Request for Action (RFA): A form completed by the Support Coordinator to request approval from the regional office when there is a need for a change to services being provided.
11. HCBS: Home and Community Based Services.
12. ADMH-DDD: Alabama Department of Mental Health-Division of Developmental Disabilities

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:
        i. 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
        ii. 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.
        iii. 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.



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

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

Definitions: CWP (Community Waiver Program); PPQ (Preferred Provider Qualifications); P&Q (Planning & Quality Assurance Specialist); ADMH/DDD (Alabama Department of Mental Health/Division of Developmental Disability); HCBS (Home and Community-Based Services); 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.

   <u>Eligibility to respond to the RFP includes</u>:
   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 <u>and</u> that has no substantiated findings of abuse, neglect, mistreatment, or exploitation within the past 12 months.
   AND
   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.
    i. 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 Initial Credentialing 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 Committee confirms, through this review, that provider meets all necessary requirements and documents this confirmation.
        i. All new CWP providers must go through initial credentialing process to confirm the provider meets minimum qualifications as outlined in the approved CWP waiver applications, HCBS Settings Rule standards and verifying the minimum score required on PPQs.
            1. For providers responding to any RFP, the response must contain evidence to confirm the provider meets all of these requirements.
            2. 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:
    i. The provider must submit documentation that verifies the setting(s) meets all HCBS Settings Rule standards including the additional standards applying to provider owned or controlled residential settings, and
    ii. 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).
    i. 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.
    ii. 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. CWP Quality Enhancement staff will conduct monthly technical assistance during the TOA; but once the provider starts serving at least one CWP enrollee, the CWP Quality Enhancement staff will switch to monthly Credentialing visits, accomplishing the first full Credentialing review over a twelve-month period.

m. Within the timeframe of the TOA, but after the provider has begun serving at least one CWP enrollee, CWP Quality Enhancement staff will begin the monthly credentialing activities which include onsite and virtual visits to review alignment with performance indicators as well as opportunities to gather input from people served, provider staff, and families/guardians.

    i. This is an initial credentialing process occurring across 12 months whereby a provider is considered to be "in good standing" as long as they are found to be in alignment with credentialing requirements as they are addressed at each monthly visit.
    ii. If the provider is found not to be in alignment with any credentialing requirements, to be considered "in good standing" the provider must be actively engaged in the process of coming into alignment with the requirements through implementation of an ADMH-approved Plan of Alignment to be developed and submitted to the P&Q Specialist within 14 days.. (Lack of alignment with a <u>compliance</u> indicator will require the provider to fully implement the Plan of Alignment within 90 days to resolve the noncompliance.)
    iii. All providers will also be expected to develop a plan to improve quality and move toward ever-increasing excellence (Plan of Excellence) for an area where the provider is meeting or exceeding expectations, which includes increasing their PPQ score over time.
    iv. The Quality Enhancement staff will support the provider to design Plans of Alignment to bring areas of non-alignment into alignment. The QE Staff will also support the provider to develop Plans of Excellence. Each Plan for Alignment and Plan for Excellence will specify what the provider will do and how the department will support those activities, as well as determine when they are satisfactorily completed.
    v. If ADMH/DDD determines that a provider is not participating in this process of initial credentialing, due to the fact the provider is <u>not</u> actively participating in monthly visits, <u>not</u> providing necessary policy/practice documentation or access to settings, individuals served and/or staff, <u>not</u> timely completing required Plans of Alignment, and/or <u>not</u> providing adequate practice evidence of their alignment with CWP provider requirements, ADMH/DDD will initiate the process outlined in the CWP contract to withdraw the provider's TOA and terminate the provider's ability to continue providing CWP services.
    vi. This initial Credentialing, if successfully completed by the provider, will be documented, and maintained in the provider's ADMH file.
    vii. The provider will then be engaged in re-credentialing (see 3. below).

n. 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.

3. **Community Waiver Program (CWP) Re-Credentialing and Continuous Quality Improvement Process**
    a. The CQI and Re-Credentialing Process begins immediately after the initial credentialing process is completed.
    b. Ongoing re-credentialing, necessary for the provider to continue in the CWP network, occurs through monthly visits, conducted both virtually and in-person, by ADMH/DDD P&Q Specialist. (***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 against both compliance and quality indicators specific to each CWP service they are providing. Compliance indicators include HCBS Settings Rule standards (see g. below for more information).
    d. 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 identification of any training and/or technical assistance needs which can be met through the ADMH/DDD CWP Provider Readiness Initiative.
    e. Each monthly credentialing visit will focus on specific compliance and quality requirements for re-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 for ease of gathering/sharing and analyzing information and data.
    f. At a minimum of one in-person monthly visit per year, the focus will be on reconfirming full compliance with HCBS Settings Rule standards.
    g. The P&Q specialist will use a HCBS Settings Rule Standards Review tool to reconfirm the following:
        i. All necessary policies are in place, policies previously found compliant remain in use and/or new/modified policies can be found compliant.
        ii. Practice evidence specific to CWP participants is available to support full compliance with HCBS Settings Rule standards.
        iii. Results of Individual Experience Assessments for CWP participants served by the provider, when considered in the aggregate, support full compliance with HCBS Settings Rule standards. *Note: The P&Q Specialist will obtain the relevant Individual Experience Assessments from the ADIDIS system where they are entered by Support Coordinators who conduct these assessments annually with CWP participants.*
    h. If the provider has any provider owned or controlled residential settings serving CWP participants, the P&Q will visit these settings a minimum of once a year, using the HCBS Settings Rule Review tool section addressing the HCBS standards particular to these types of settings and ensuring through observation, interviews with staff and individuals served, and review of practice evidence specific to the setting that full compliance with HCBS Settings Rule standards continues.
    i. Rather than a once per year visit, this credentialing process is designed to be an ongoing, monthly process, completed on 12-month cycles, 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 and moving toward ever-increasing excellence.

j. For any areas found not to be in alignment with compliance and/or quality indicators during the re-credentialing process, the P&Q Specialist will support the provider to design a plan to bring areas identified into alignment. Each "Plan for Alignment" will document what the provider will do and how ADMH/DDDD will support those activities, as well as determine when they will be satisfactorily completed.

k. For alignment needed to meet compliance indicators, including HCBS Settings Rule compliance, the satisfactory completion of the Plan for Alignment must occur within no more than ninety (90) days; in some cases, thirty (30) or sixty (60) days to ensure the provider can continue as a credentialed CWP provider.

l. For alignment needed to increase quality, a Plan(s) for Alignment for the next year will be developed collaboratively by the P&Q Specialist and the provider. All providers will be required to have at least one Plan for Alignment focused on increasing quality in each year of the cycle: this Plan must focus at least in part on how the provider will increase its PPQ score, and the plan will include identification of any training and/or technical assistance needs which can be met through the ADMH/DDD CWP Provider Readiness Initiative.

m. 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.

n. If at any time ADMH/DDD determines that a provider is not participating in this process, which is defined as not actively participating in bi-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 with CWP provider requirements, ADMH/DDD will initiate the process outlined in the CWP contract to withdraw the provider's credentialed status in the CWP and the provider's ability to continue providing CWP services.

4. Additional Information on Monthly Credentialing Visits to Organization

a. Prior to each monthly visit, the P&Q staff coordinate dates and logistics, either in-person or virtual, for the visit. Care should be taken to ensure the provider includes all pertinent staff involved in the CWP for the P&Q staff to be able to gain the most thorough and accurate information available.

b. At the first visit, the P&Q staff provides a detailed outline of the CWP Credentialing Process. The P&Q staff explains that "credentialing" is to:

    i. Assist providers to consistently maintain minimum compliance while also looking to improve their expertise and quality of service delivery to achieve performance beyond basic compliance.

    ii. Effectively utilize data tracking to assist providers with goals, resulting in demonstrated quality service provision individualized to each CWP participant served.

c. After the first visit, the P&Q staff will start each monthly visit hearing from the provider about success stories they wish to highlight since the last visit. In addition, they will discuss the following:

    i. issues, barriers, difficulties that have arisen,

    ii. troubleshooting/problem solving strategies to address the identified issues, barriers, and difficulties; and

iii. how ADMH/DDD will support the provider with resources, technical assistance, and training.

d. At each monthly visit the P&Q staff completes "Focus Groups" with the staff, individual and family/natural supports. The "Focus Groups" engages in guided conversations to gather information as it relates to the person being served as well as the service provision by the provider.

5. **Credentialing Tool**
   a. The provider will complete the Credentialing Tool for each service the provider is authorized to provide, if they are currently actively serving CWP participant(s) in that service.
   b. The P&Q Specialist will look at each compliance and quality performance indicator and review and document the evidence the provider has of their alignment with each indicator.
   c. A consensus decision between the P&Q Specialist and the provider will be made as to whether the evidence shows the following:
      i. The provider meets the performance indicator
      ii. The provider exceeds the performance indicator
      iii. Action required by the provider to address lack of full alignment with the performance indicator
   d. If the P&Q Specialist and provider cannot reach consensus, the P&Q staff will involve at least one additional P&Q Specialist to conduct a blind review of the evidence and render a decision.
   e. For each compliance and quality performance indicator that needs action, a Plan of Alignment will be developed and submitted within 14 days. It is not necessary to have a separate Plan of Alignment for each individual indicator if a single Plan of Alignment might cover activities designed to bring multiple indicators into full alignment.
   f. At least one Plan of Excellence must be developed and adopted each year and must include, at minimum, increasing the PPQ score.

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

Note: Provider Certification Forms

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

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

Definitions: 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:
        i. Documentation of the rationale for providing the requested services prior to admission to Waiver services; and
        ii. 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

Responsible Office: Community Waiver Program

Reference: ADMH Administrative Code 580-5-30; ADMH Policy

Effective: January 20, 2022

Statement: The Developmental Disabilities Division (DDD) of the Alabama Department of Mental Health shall ensure the Community Waiver Program (CWP) maintains a an adequate network of qualified providers that are: (1) recruited through a Request for Proposal (RFP) process; (2) meet Preferred Provider Qualifications (PPQs) as set forth in applicable waiver agreements governing the CWP; and (3) are selected based on RFP score, consistent with the standards, terms and conditions set forth in applicable waiver agreements governing the CWP. Further, monitoring of provider network adequacy shall be done in a systematic way, consistent with the standards, terms and conditions set forth in applicable waiver agreements governing the CWP.

Purpose/Intent: To provide clear and concise steps by which the DDD will monitor CWP provider network capacity and as needed, recruit, select and enroll additional providers of CWP services that meet PPQs as established for the CWP (see Attachment A) and are selected through a competitive RFP process.

HCBS Waivers: CWP

Definitions:

1. Quarterly Average Referral Acceptance Rate is defined as follows: of the total number of beneficiaries referred to one or more providers for the service during the quarter in a region, the percentage whose referrals were accepted by a provider during the quarter and up to fourteen (14) days beyond the end date of the quarter. This data will be collected by the support coordination providers.
    a. Numerator: Total number of beneficiaries whose referrals were accepted by a provider during the quarter and up to fourteen (14) calendar days beyond the end date of the quarter in each region.
    b. Denominator: Total number of beneficiaries referred to one or more providers for the service during the quarter in each region.
2. Quarterly Average Timeframe from Referral Acceptance to Service Initiation is defined as the average number of days from referral acceptance to service initiation across total number of beneficiaries who had the service initiated during the quarter in that region. The timeframes will be calculated by provider reported data and support coordination providers.
    a. Numerator: Cumulative number of days from referral acceptance to service initiation for all service initiations in the quarter specific to the service type and region.
    b. Denominator: Total number of service initiations in the quarter specific to the service type and region.
3. CWP Demonstration Areas are defined as the following:
    - Region 1: Madison, Morgan and Limestone counties
    - Region 2: Tuscaloosa and Walker counties
    - Region 3: Baldwin and Mobile counties
    - Region 4: Elmore, Houston, and Montgomery counties
    - Region 5: Jefferson county

Preferred Providers are defined as qualified providers meeting the PPQs approved for the CWP demonstration by CMS (see Attachment A).

Procedures:

1. The DDD shall adhere to PPQs approved by CMS as the primary method for recruiting, selecting and enrolling providers for the CWP.
   a. The DDD shall establish and maintain an adequate number of Preferred Providers to deliver CWP services in each of the five CWP regions of the state.
   b. Adequate provider capacity shall ensure, at minimum, choice of two qualified service providers per service in each of the five regions in order to meet the needs of CWP enrollees. Note: A single provider may qualify as one of the two possible providers for multiple services in multiple regions; but can never occupy both provider slots for a single service in any region.
   c. Beyond this, the size of the provider network for services in the demonstration areas shall be based on prospective capacity of the existing network providers and the anticipated needs of existing and new enrollees. The provider capacity should be adequate to ensure each CWP enrollee has the choice of at least two qualified service providers for each service in their person-centered plan.
2. Exceptions to 1. in this section of the OG:
   a. Support Coordination services are limited to one provider in each of the five regions of the state. The DDD shall ensure Support Coordination services are provided by DDD-employed staff in CWP counties in Regions 1, 3, 4 and 5. Support Coordination Services shall be provided by qualified 310 Boards in CWP counties in Region 2, or if no willing and qualified 310 Boards are available, by DDD-employed staff.
   b. Other CWP services that do not require Preferred Providers include: Services self-directed by enrollee or their representative acting as employer of record; Natural Support and Caregiver Education and Training; Community Transportation; Minor Home Modifications; Physical Therapy; Occupational Therapy, and Speech and Language Therapy.
3. For services other than those listed in 2. in this section of the OG, DDD shall engage a competitive solicitation and recruitment process in accordance with departmental policies and procedures, applicable state and federal laws, regulations and policies, and the standards, terms and conditions set forth in applicable waiver agreements governing the CWP.
   a. RFPs shall be issued through the ADMH Office of Contracts and Procurements, unless otherwise specified by the DDD.
   b. RFPs shall be issued for a specific service(s) in a specific CWP county(ies) when monitoring of provider network capacity demonstrates a need for one or more additional providers.
   c. Providers will be selected based on their PPQ score, willingness to provide service(s) for which additional capacity is needed in the county(ies) where the service(s) is needed, and results of competitive RFP process.
   d. The number of providers selected in an RFP process will be based on anticipated needs of existing and new enrollees not met by existing providers' reported prospective capacity.
4. Methods for Monitoring Provider Network Capacity
   a. The DDD will monitor provider capacity for the Community Waiver Program demonstration as follows:
   b. The DDD will increase the number of preferred providers for each needed service, by region, when any of the following occur:

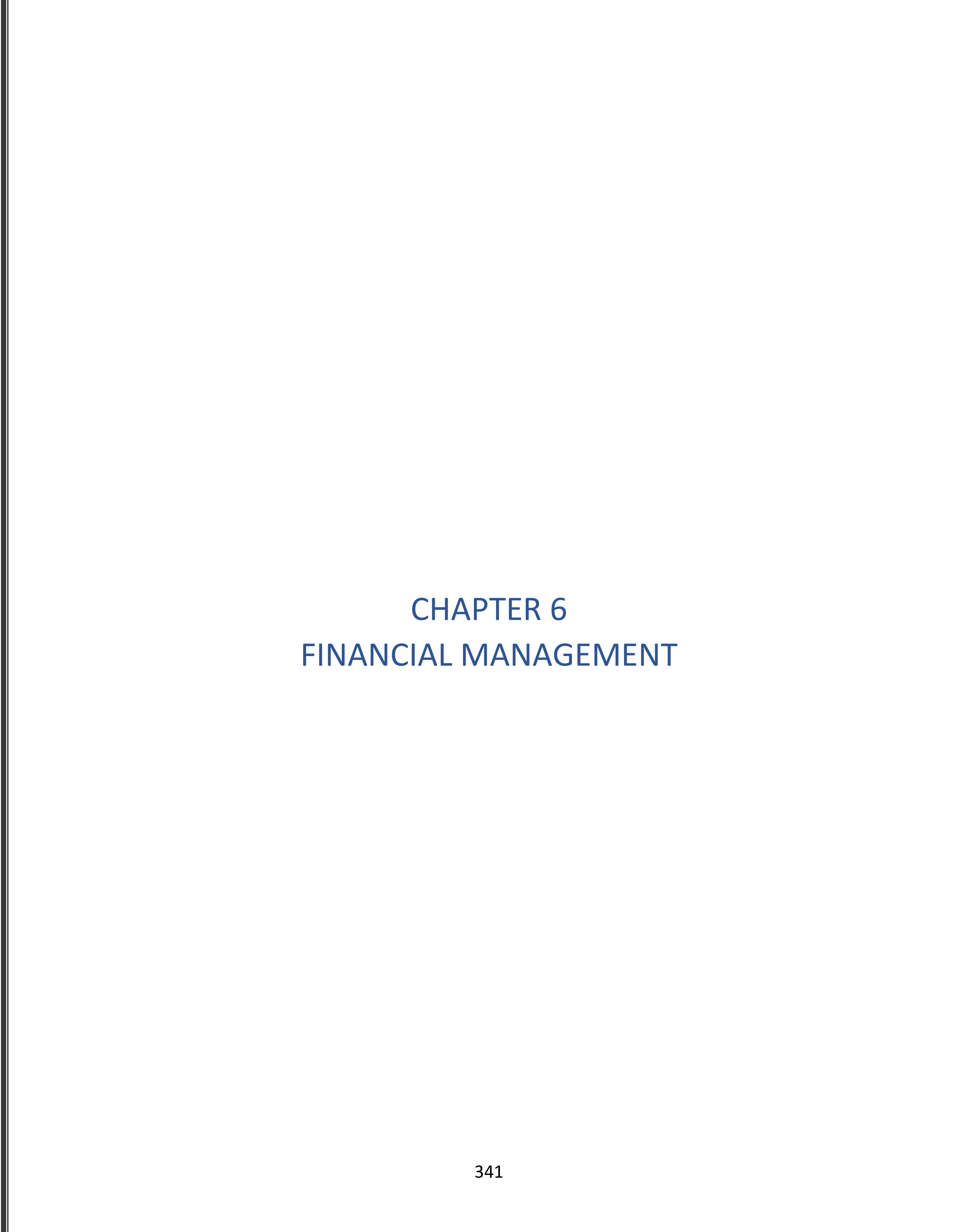
i. Quarterly average acceptance rate drops below 80% during a public health emergency (PHE) or drops below 90% in all other periods.
ii. Quarterly average timeframe from referral acceptance to service initiation exceeds 60 days during a PHE or exceeds 45 days in all other periods.
iii. When one or more providers report they are unable to expand the number of beneficiaries they are serving in a particular service and region to meet anticipated demand.

5. Provider Capacity Determinations, Recruitment and Selection
   a. The DDD will determine the provider capacity needed based on existing and anticipated need for a particular service in each region by:
      i. Identifying how many beneficiaries did not have a referral accepted during the quarter under review.
      ii. Identifying how many beneficiaries had a referral accepted but did not have timely service initiated during the quarter under review.
      iii. Determining anticipated need for additional capacity based on state's plan to expand total enrollment slots in the region within the next twelve months and calculating how many new enrollees are projected to use the service based on existing utilization rates in the region; and
      iv. Doubling the total additional capacity needed as a result of 5.a.i, ii, and iii above to ensure a minimum of two providers per service for each region and to preserve enrollee choice as noted in 1.c.
   b. Upon determination that additional provider capacity for a CWP service(s) is needed, a RFP will be issued for the specific service(s) in the specific region(s) where the service(s) is needed.
   c. Provider respondents will be approved for possible selection if all basic required qualifications are met and PPQs are met as outlined in the Attachment A.
   d. Among approved providers, the provider(s) selected will be based on RFP score, which will be based on the following as detailed in the RFP:
      i. Provider's Preferred Provider Qualifications score (at least 45% of score will be based on PPQ score)
      ii. Provider's knowledge and understanding of the services to be provided, and relevant expertise, capabilities, technical competence, and/or any experience, training or qualifications that the provider agency's staff have relevant to the services.
      iii. Size of geographic area (including number of counties) in which the provider is proposing to provide services.
      iv. Evidence of ability to undertake necessary investments and steps to begin providing services by target date for additional capacity to be available.
      v. Number of referrals the provider indicates capacity to receive.
   e. If a provider respondent meets basic required qualifications and PPQs but is not selected due to capacity needs being met by higher scoring providers, the provider will be considered for placement on a Provider "Stand by List" or for being given "Priority Status".
   f. The Provider "Stand by List" will include the highest scoring provider of those not selected for each service for each region in which there was an RFP. The "Stand by" Provider can be

contracted to immediately provide services to CWP enrollees when there is a need for increased provider capacity and while a RFP process is going on to recruit the additional provider capacity.

g. All other provider respondents meeting basic required qualifications and PPQs but not selected for immediate contracting or placement on the “Stand by List” will be given “Priority Status” which will relieve the provider of having to complete and submit an entirely new application when a subsequent RFP for services is issued. To respond to a subsequent RFP, these providers will only need to formally notify ADMH, by the deadline for the RFP submission, of their desire to be considered in the subsequent RFP process and along with this formal notification, to submit any updates to information in their application as needed to reflect changes.

6. Provider Enrollment and Certification
   a. Provider respondents selected for contracting will be required to become certified by ADMH-DDD for the Community Waiver Program.



CHAPTER 6
FINANCIAL MANAGEMENT

B.6.1 Community Waiver Program Slot Reallocation Process

Responsible Office: Community Waiver Program

Effective: April 13, 2022

Revised: June 17, 2022

Statement: A slot reallocation strategy will be utilized in the event slot capacity is reached in a particular enrollment group and/or region while excess slots are determined to be available in other regions and/or enrollment groups.

Purpose/Intent: Available CWP slots will be managed on an ongoing basis and reallocated to different regions and/or enrollment groups to meet immediate demand and ensure full utilization of all available slots.

HCBS Waivers: CWP

Definitions: Alabama Department of Mental Health/Division of Developmental Disabilities (DDD); Community Waiver Program (CWP)

Procedures:

1. In the event that slot capacity is reached for a specific enrollment group in a specific CWP region, the CWP Director will evaluate slot allocation across all regions and enrollment groups to determine if slot reallocation can be implemented by transferring unused capacity to create more capacity where needed.
2. The CWP Director will weekly:
    a. Review the CWP WL Outreach Tracking – Accepted Slots and Updated Allocations report in Microsoft Teams MH-ID/LAH/CWP Waiting List Channel.
    b. Any enrollment group in any region showing zero (0) remaining slots will be identified.
    c. As a first step to replenishing slots in the enrollment group/region showing zero remaining slots, the remaining slots available in the same enrollment group in all other regions shall be identified as a percentage of total allocated slots. Example:
        Region 1: 0 of 90 slots remaining (needs reallocation of slots)
        Region 2: 10 of 50 slots remaining (20%)
        Region 3: 40 of 100 slots remaining (40%)
        Region 4: 5 of 50 slots remaining (10%)
        Region 5: 25 of 50 slots remaining (50%)
    d. Available slots in the same enrollment group will be moved to the region with no remaining slots using the following process steps:
        i. The region with no slots remaining will receive enough reallocated slots to equal 10% of total allocated slots, before reallocation. Example: Region 1 was allocated 90 slots and used them all. Reallocation will ensure Region 1 receives 9 additional slots, which is 10% of their original 90 slots.
        ii. To reallocate slots to the region with no slots remaining, slots will be moved first from the region(s) with the highest percentage of remaining slots. Example: Region 5 has 50 allocated slots and 25 remaining. This means they have 50% remaining. No other region with remaining slots has a percentage remaining that is higher than 50%. Therefore, slots will be moved from Region 5 until the remaining percentage matches the region with the next highest percentage. Example: Region 5 has 50% of slots remaining. Region 3 has 40% of slots remaining. Therefore, up to 10% of slots from Region 5 can be

reallocated from Region 5, bringing its % of slots remaining to no less than 40%.)

Region 1: Needs reallocation of 9 slots; receives 5 slots from Region 5
Region 2: 10 of 50 slots remaining (20%)
Region 3: 40 of 100 slots remaining (40%)
Region 4: 5 of 50 slots remaining (10%)
Region 5: 20 of 50 slots remaining (40%)

iii. If the region requiring the reallocated slots (in the amount of 10% of its total of previously allocated slots) still requires more slots after step 2.d.ii is completed, slots will be taken in equal amounts from the regions with the highest percentage of remaining slots. (Example: Regions 3 and 5 both have 40% of their allocated slots remaining. Region 1 still needs 4 additional slots. 2 slots each will be taken from Region 3 and 5 to provide Region 1 with the additional slots it needs.

Region 1: Needs reallocation of 9 slots; receives a total of 7 slots from Region 5 and 2 slots from Region 3
Region 2: 10 of 50 slots remaining (20%)
Region 3: 38 of 100 slots remaining (38%)
Region 4: 5 of 50 slots remaining (10%)
Region 5: 18 of 50 slots remaining (36%)

e. If the remaining slots available in the same enrollment group in all other regions is 10% or less, per result of step 2.c. above, no slots shall be moved to the region showing zero (0) remaining slots. The CWP Director will instead take the following steps to replenish the slots:
   i. Available slots in other enrollment groups <u>in the same region</u> will be assessed, based on number and expenditure cap (dollar value) associated with these slots as compared to the expenditure cap (dollar value) associated with the slots that need to be replenished.
   ii. If slots with a higher expenditure cap exist and are available, these can be converted to create slots with a lower expenditure cap as long as <u>no less overall slots (for the CWP as a whole) result from the conversion</u>. **IMPORTANT NOTE: If higher expenditure cap slots are in Group #4, conversion of these slots cannot be done unless enough slots remain for reserve capacity needs and at least 15% of total CWP slots will remain in Group #4 after the conversion**.

f. If steps 2. e. i and 2.e.ii are implemented, but the number of slots needed to replenish the enrollment group showing zero available slots is still not sufficient, the CWP Director will take the following steps to replenish the slots:
   i. The CWP Director will consider the remaining slots available <u>in the same region</u> and in the enrollment group with the closest lower expenditure cap. These slots shall be identified as a percentage of total allocated slots. Example:

Region 1 – Group 3: 0 of 90 slots remaining (needs reallocation of slots)
Group with closest lower expenditure cap: Group 2
Region 1 – Group 2: 8 of 20 slots remaining (40%)

ii. If more than 10% of slots remain in the enrollment group with the closest lower expenditure cap, the CWP Director will consider the availability of dollars, for the current waiver year, set aside for Minor Home Modifications and approvals to exceed expenditure caps. If waiver year utilization to date for these dollars is less than budgeted (see Example A below), the CWP Director will transfer dollars from this set-aside fund in the amount necessary to pair with funding attached to the available slots from the enrollment group with the closest lower expenditure cap to create the slots needed to replenish the enrollment group that was showing zero available slots (see Example B below).

Example A:
Waiver year total budget for Minor Home Modifications and approvals to exceed expenditure caps: $3,000,000.
Waiver yea-r completed to date: 6 of 12 months (50%)
Pro-rated waiver year total budget for Minor Home Modifications and approvals to exceed expenditure caps: $3,000,000 X 50% = $1,500,000.
Actual total authorized to date for Minor Home Modifications and approvals to exceed expenditure caps: $800,000.
Actual versus budgeted: Actual is $700,000 less than budgeted.
Example B:
Region 1 – Group 3: Still needs reallocation of 4 slots.
Group with closest lower expenditure cap: Group 2
Region 1 – Group 2: 8 of 20 slots remaining (40%)
Region 1 – Four (4) Group 2 slots are moved to Group 3. The dollars associated with these Group 2 slots are also moved to Group 3. The Group 2 slots are worth $15,000 each. The Group 3 slots are $30,000 each. An additional $15,000 per slot is needed from the set-aside budget for Minor Home Modifications and approvals to exceed expenditure caps. The CWP Director moves $60,000 from the set-aside budget for Minor Home Modifications and approvals to exceed expenditure caps to fully fund the four (4) Group 3 slots created through the transfer of the available Group 2 slots.

iii. If no or insufficient slots are available in the same region and in the enrollment group with the closest lower expenditure cap, the CWP Director will apply the same process described in 2.f.i and 2.f.ii to the enrollment group in the same region with the next closest lower expenditure cap. (Example: If the process in 2.f.i and 2.f.ii was done with Group 2 as the examples above illustrate, and this does not result in enough new slots for Group 3, the CWP Director will apply the same process to Group 1.)

g. If steps 2.f.i through 2.f.iii are implemented, but the number of slots needed to replenish the enrollment group showing zero available slots is still not sufficient, the CWP Director can repeat the steps in 2.f.i through 2.f.iii for slots available in other regions, so long as the total remaining slots in the other regions' enrollment groups do not drop below 10% of the total allocated slots.

h. When all of the above methods do not result in sufficient slots for reallocation to the region and enrollment group that was showing zero (0) available slots, the process will be completed and

the enrollment group in this region will be closed to new enrollments until the process above is repeated and additional slots are able to be created in this region/enrollment group OR until the total number of unduplicated slots in the CWP is increased and a portion of these new slots can be added to this region/enrollment group.

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

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

Definitions: Alabama Department of Mental Health/Developmental Disabilities Division, 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. 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.
2. 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.

3. 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.
4. The accepting FMSA will access the list of transfer records by secure email/file access.
5. If the payment is not received by the accepting FMSA within 7 working days, the FMSA should follow up with the DMH Finance office.

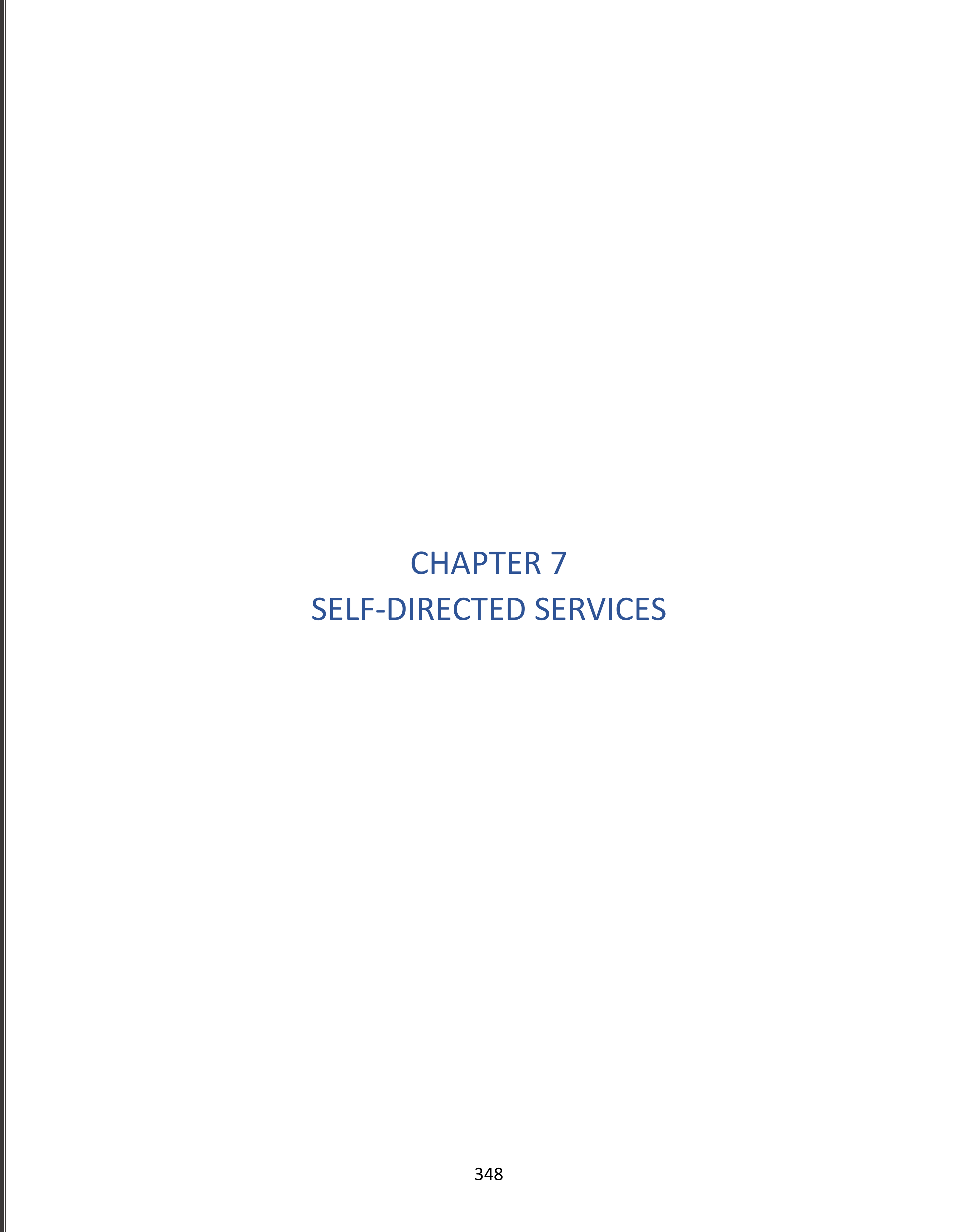
New Financial Management Service Agency:

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.

*Note: Financial Management Services Agency (FMSA) Transfer Form *(See List of Forms Table)*



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
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
Definitions: Community Waiver Program (CWP); Self-Directed Services (SDS) – A service delivery option; Alabama Division of Developmental Disabilities Information System (ADIDIS); Financial Management System Agency (FMSA) – Agency that provides payroll services to individuals who select SDS; Employer of Record (EOR) –Individual who hires, supervises, schedules, trains, as needed dismisses, and approves timesheets and other documentation for SDS workers; 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

2. 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.
3. 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.

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.

*Note: *See List of Forms Table for the following*:

"Deciding if Self-Direction is Right for You" tool

Free Choice form

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

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.

Purpose/Intent: Provide rules for CWP Budget Savings Accounts

HCBS Waivers: CWP

Definitions: 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.[1]
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**

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[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.

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:

    <u>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</u> 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.

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

Responsible Office: Community Waiver Program

Reference: Microsoft Word - AUDIT GUIDE 2016.rtf (alabama.gov); Internal-Audit-Managers-Letter.pdf (alabama.gov); HCBS Rule Residential Setting-Specific Transition to Compliance Plan.xlsx (alabama.gov); HCBS Rule Non-Residential Setting-Specific Transition to Compliance Plan.xlsx (alabama.gov); Alabama ABLE; HCBS Settings Rule; Assessment Tool for Certification Reviews

Effective: March 10, 2022

Revised: June 7, 2022

Statement: The Alabama Department of Mental Health (ADMH), Division of Developmental Disabilities (DDD) has created a Provider Money Management Guide to improve financial wellness, cultivate financial accessibility and financial inclusion, and foster financial independence for individuals served with developmental and/or intellectual disabilities.

Purpose/Intent: Money management provision for individuals receiving waiver services must comply with Home and Community Based Services (HCBS) Settings Rule Standards in ensuring that all individuals served exercise their preferences in accessing and managing their own money, are trained in understanding basic money management principles, and are given options relative to available resources that benefit their overall financial wellbeing. Additionally, providers must ensure funding for services and supports for individuals are allocated, monitored, and tracked according to federal/state auditing and reporting guidelines, fiscal standards, and operational guidelines.

HCBS Waivers: CWP

Definitions: Home and Community Based Services (HCBS) - Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources

Procedures:

ADMH-DDD has developed the following money management indicators which serve as a guidance tool for providers and individuals served:

5. **Rights & Privileges**
   a. **Individual**
      i. Must be given the option to decide how to spend, save, keep, give away, invest, or direct their money
      ii. Must be provided the option to possess a checking or savings account, or other means to control his/her funds (i.e., debit card, refillable debit card, or personal checks, etc.)
      iii. Must be offered informed choices to control monetary resources
      iv. Must be offered training in utilizing their own money
      v. Offer to assist individuals served with money management (individualized budget) of their funds
      vi. Ensure timely/prompt access of monetary funds as requested by individuals served
      vii. Ensure that individual needs are met and sustained
      viii. Provide training to individuals served on how to access and manage their money
      ix. Optimize individuals served independence in accessing and using money
      x. Ensure individual preferences are supported and rights are protected
      xi. Ensure services and supports are self-directed

   b. **Provider**
      i. Offer to assist individuals served with money management (individualized budget) of their

funds

ii. Ensure timely/prompt access of monetary funds as requested by individuals served

iii. Ensure that individual needs are met and sustained

iv. Provide training to individuals served on how to access and manage their money

v. Any modifications of conditions of HCBS must be supported by a specific assessed need and justified in the PCP

c. **Outcomes**

i. Optimize individuals served independence in accessing and using money

ii. Ensure individual preferences are supported and rights are protected

iii. Ensure services and supports are self-directed

6. Access to Money

a. **Individual**

iii. Must be able to access funds at will

iv. Provided the option to manage his/her own personal funds

b. **Provider**

vi. Maintain a separate account for individuals served

vii. Provide individuals served monthly reports of expenditures

viii. Offer individuals served the option to create an Able Savings Plan to store monies with a maximum allowable balance of $100,000

ix. Ensure that available funds on-site (petty cash) do not exceed $300 per individual

x. Provide an assessment tool to help manage funds for individuals served who choose not to manage their own funds

c. **Outcome**

iii. Promote financial independence for individuals served

iv. Ensure individuals served spend their money in a manner reflecting their personal choices/preferences

7. Financial Accountability

a. **Individual**

iv. Must be provided monthly financial statements to see how individual funds are utilized

v. Must be given the option to participate in the monthly, individualized budget process

vi. Must be assured by the provider agency that their monies are kept safe and protected from fraud or misuse

b. **Provider**

v. Implement a check and balance system to include monthly review of individualized financial statements or expenditure reports with designated staff

vi. Offer monthly meetings with individuals served to discuss individual budgets and expenditures (i.e., picture board or graphics)

vii. Implement an internal, electronic financial monitoring and tracking system for individual budget expenditures (i.e., Quicken or a Microsoft Excel spreadsheet)

viii. Hire or seek consultation from a financial expert or certified accountant

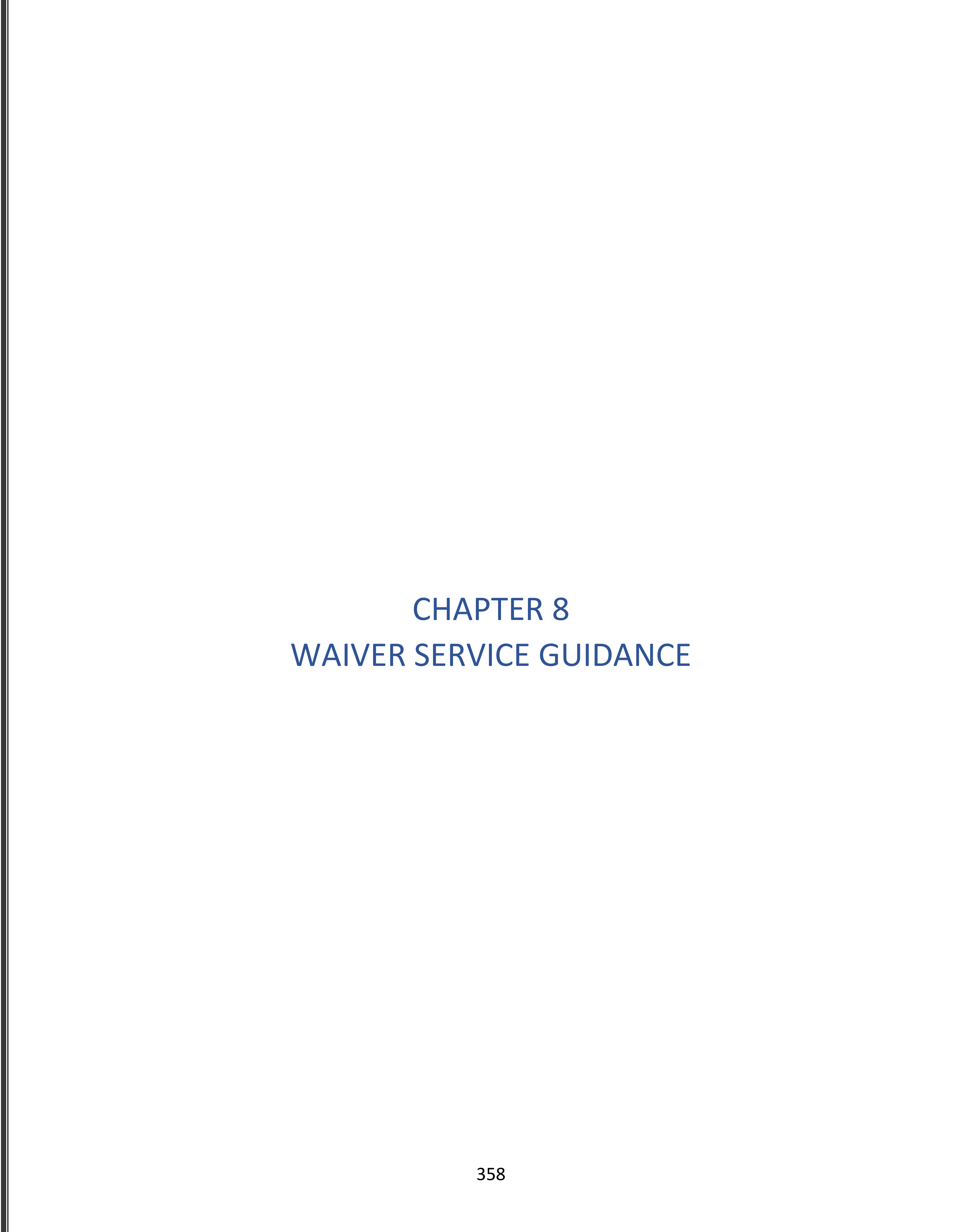
c. **Outcome**

iv. Minimize risks of budgetary inconsistencies, fraud, or improper documentation/use of federal/state funds

v. Allow for financial maintenance/sustainability in the event of auditing or staff changes

vi. Engage individuals served in seeing how their monies are disbursed according to their preferences

8. **Auditing**
    a. **Individual**
        i. Must be made aware that individual funds will be subject to auditing and reporting
    b. **Provider**
        i. Maintain a filing system of receipts (can be scanned copies electronically for additional safekeeping)
        ii. Required compliance audits are performed according to provider entity type (See Additional Resources)
        iii. Maintain fiscal records for a minimum of 3 years
    c. **Outcome**
        iv. Ensure fiscal integrity
        v. Ensure all financial transactions/recordkeeping have been properly documented in accordance with state/federal mandates
        vi. Validate individual services/supports costs



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

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

Definitions: 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:

        i. 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.

        ii. 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:

i. 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.

ii. 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

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

Definitions: 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:
        i. 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);
        ii. If the service need is covered in that it is for either or both of the following:
            1. 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
            2. Nursing procedures that meet the person's health needs as ordered by a physician.
        iii. The specific type of Skilled Nursing service and the amount of time needed. For example:
            1. Injections - 30 minutes for preparation, administration, and documentation;
            2. Wound Care – One hour for preparation, assessment, performance, and documentation;
            3. 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

Responsible Office: Community Waiver Program
Reference: DDD Community Waiver Program
Effective: July 25, 2022
Statement: Access to Minor Home Modification services outside contracted provider network
Purpose/Intent: To establish a procedure for authorizing licensed and insured contractors to provide Minor Home Modifications to individuals enrolled in the Community Waiver Program and establish a procedure for inspection/approval of the completed job.
HCBS Waivers: CWP
Definitions: Community Waiver Program (CWP)
Procedures:

1. DDD will maintain a listing of appropriately qualified, licensed, and insured contractors, registered in the STAARS system, that can be utilized to complete Minor Home Modifications. The listing will be maintained on the DDD website. DDD contracts representatives will update the listing no less than annually.
2. DDD will provide the listing to all CWP Support Coordinators who will use the list whenever they have a CWP participant that requires Minor Home Modifications and there is not an existing provider available within the contracted CWP provider network.
3. If an appropriately qualified, licensed, and insured contractor is not on the listing maintained by DDD and wants to provide Minor Home Modifications for CWP participants, the contractor will contact the DDD central office contracts representative for instructions on required documentation and enrollment in STAARS. Once this documentation and STAARS enrollment is completed, the contractor can be added to the DDD listing.
4. When a person-centered planning process results in the identification of a need for a Minor Home Modification for a CWP participant, the Support Coordinator will document this in the person-centered plan and seek supervisory approval for the medical necessity of the modification. The Support Coordination Supervisor will document the approval or denial, and basis for the approval or denial, as a note in the ADIDIS record for the CWP participant. Any denial will be formally communicated to the CWP participant, with information on appeal rights.
5. If the Minor Home Modification is approved, and there is not an existing provider available within the contracted CWP provider network, a referral can be made to a contractor on the DDD listing. The CWP participant's Support Coordinator will search on the listing (on the DDD website) to find qualified contractors. The Support Coordinator will present the list of qualified contractors to the CWP participant, and s/he will choose a contractor(s) from the list.
6. The Support Coordinator will contact the contractor(s) and arrange for an estimate for the job to be completed as defined in the person-centered plan. Estimates must include and address compliance with local building codes (including permits) and the Americans with Disabilities Act (ADA).
7. All estimates must be approved and accepted by DDD Chief Financial Officer. All estimates must be for no more than $5,000. If multiple estimates are received for the same job, the lowest estimate will be accepted.
8. Upon completion of the project, proof of local building inspector final approval (if building permit required) or passage of inspection by an engineer to ensure ADA compliance and safe construction or approval by the Support Coordinator and the participant/family/guardian signature on the ***Satisfaction of Services Form*** are required prior to payment. Once these

approvals are obtained, the contractor will send an invoice to DDD Central Office (Attention: Billing Staff) along with copies of the approval(s). The Satisfaction of Services Form will be uploaded into the ADIDIS in the participant file.

9. DDD billing staff will process the Medicaid billing under DDD's National Provider Index number and upon DDD receiving Medicaid reimbursement, the payment to the contractor will be processed by DDD.

*Note: Satisfaction of Services Form (*See List of Forms Table)*

B.8.4 External Waiver Transfers to CWP

Responsible Office: 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
Definitions: Alabama Department of Senior Services (ADSS), Alabama Department of Rehabilitation Services (ADRS) and 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.
        1. 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.
3. If the applicant expresses interest, the Support coordinator must determine any extenuating circumstances supporting the need for the transfer.
4. 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
Operational Guideline B.1.1	*Initial Contact Information Form*
Operational Guideline B.3.3	*Request for Regional Action (RFA) & Instructions*
Operational Guideline B.3.5	*Individual Experience Assessment Survey (IEA)*
Operational Guideline B.3.6	*Freedom of Choice Form*
Operational Guideline B.3.7	*CWP Request for Proposal (RFP) to Provider Waiver Services*
Operational Guideline B.3.8	*Request for CSS Consultation*
Operational Guideline B.4.3	*Rent Residency Agreement Guidelines*
Operational Guideline B.5.1	*CWP Provider Application*
Operational Guideline B.5.1	*CWP Service Proposal*
Operational Guideline B.5.1	*Plan for Alignment*
Operational Guideline B.5.1	*Plan for Excellence*
Operational Guideline B.5.1	*Administrative Functions Visit Form*
Operational Guideline B.5.1	*Communications Visit Form*
Operational Guideline B.5.1	*Staffing Visit Form*
Operational Guideline B.5.1	*Values Visit Form*
Operational Guideline B.5.1	*Preferred Provider Qualifications (PPQ)*
Operational Guideline B.6.2	*Financial Management Services Agency (FMSA) Transfer Form*
Operational Guideline B.7.1	*Deciding if Self-Direction is Right for You*
Operational Guideline B.7.3	*Provider Money Management Guidance*
Operational Guideline B.8.3	*CWP Client Satisfaction Form for Minor Home Modifications*

ADMH-Division of Developmental Disabilities **Call Center**	**INITIAL CONTACT INFORMATION FORM**		
Caller Information	**Applicant Information**		
Name of Caller:	Applicant Name (if different from Caller):		
Relationship to applicant: ☐ Self (applicant) ☐ Legal Guardian ☐ Family (not Legal Guardian, describe) ☐ Other	Date of Birth:	Age:	Gender: ☐ Female ☐ Male
	SS#: Medicaid#:		
Street/Box Address City/State/Zip	Street/Box Address City/State/Zip		
County:	**County:**		
Home Phone #: Work #: Cell #:	Home Phone #: Work #: Cell #:		
Email address:	Email address:		
Military Affiliation Active (of whom? Caller or person being referred?): ☐Yes ☐No Whom:	**Our Vision: A continuum of care focusing on…** Keeping families together Supporting productivity and Community Inclusion Reaching those in need **ADMH-DDD Staff are "MAKING A DIFFERENCE"**		
Best Contact Time: A.M. P.M. Anytime			
Reported Diagnosis:			
Intellectual Functioning:			
Medical Conditions (e.g., seizures; constipation; heart issues; incontinence; other):			
Impairments (e.g., Physical; Vision, Mobility, Hearing):			

Residence Type:

Does the person lease/rent or own their own home? ☐ Lease/Rent ☐ Co-Lease/Rent ☐ Own ☐ Co-Own

Which of the following best describes current residence of applicant?

☐ Lives in home owned by self ☐ Lives in home owned by family member(s) ☐ Lives in home leased/rented by self

☐ Lives in home leased/rented by family member(s)

☐ Lives in home co-leased/rented with others (specify how many others and relationship to applicant)

☐ Lives in home co-owned with others (specify how many others and relationship to applicant)

☐ Lives in home owned by a paid service provider (if yes select one from the following):

☐ Facility 16+ residents ☐ Group Home (7-15 residents) ☐ Group Home (1-6 residents)

☐ Youth Foster Home ☐ Adult Host Home ☐ Other (specify):

☐ Homeless (specify shelter; on street; in car; other):

☐ Other (describe):

Income:
Employment: ☐Yes ☐No Employer: Avg Hours/Week: Avg Income/Week:
Other Income Source(s):
☐SSI $ per month ☐SSDI $ per month ☐Other $ per month

Briefly describe current situation:

Other Assistance Programs and Community Resources that have been tried:

Legal Guardian (if applicable): ☐ Self ☐ Parent ☐ DHR ☐other
Note: For information only, is legal action being taken through the court system for someone to be declared the legal guardian? ***Explain clearly this is *not* required for the applicant to be found eligible for DDD Medicaid Waiver services.***

Name of person seeking to be named legal guardian:
Street Address:
City: State: Zip Code:
Phone: Home ( ) Work ( ) Other ( )

Additional Comments:

Type of Referral
Update of Existing Application (to 310 Board Intake Agency) ☐ **Yes** ☐ **No**
Initial Application Referral
☐ County of Residence in Community Waiver Program Pilot Area (Refer to RCS Waiting List Coordinator and corresponding 310 Board Intake Agency)
☐ County of Residence outside Community Waiver Program Pilot Area (Refer to RCS Waiting List Coordinator and Corresponding 310 Board Intake Agency)
Emergency Referral: ☐ DHR ☐ Dept of Education ☐ Court ☐ Hospital (Acute, Psych, other) ☐ DDD Autism Svc
Info/Referral Only (Describe):

Action Taken (to include name of agency the caller/applicant is referred to and why):

Checklist:
Date of Referral: Completed by:
Individual Opened in ADIDIS? ☐ Yes ☐ No If yes, enter ADIDIS Case Number:
Contact Information added to ADIDIS Record? ☐ Yes ☐ No
ADIDIS Enrollment Record completed for 310 Board Intake Agency? ☐ Yes ☐ No
Application uploaded into ADIDIS? ☐Yes ☐ No Date, if other than Date of Referral:
Which 310 Board Intake Agency? Which Region?
Referral to DHR: ☐ Yes ☐ No Date
Date, if other than Date of Referral:
Letter ☐ Yes ☐ No **Brochure** ☐ Yes ☐ No Community of Practice packet ☐ Yes ☐ No

ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES
REQUEST FOR REGIONAL ACTION (RFA)

INSTRUCTIONS FOR COMMUNITY WAIVER PROGRAM

When is an RFA required?

- Need to exceed program limit on units for a service that is in the person's PCP/POC
- Need to exceed expenditure cap
- Need to transition to a different enrollment group
- Need 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
- Need for Skilled Nursing authorization
- Need for CSST Consultation

- Any of the above situations require an RFA for approval. The Support Coordinator is responsible for preparing and submitting the RFA.

- 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.

- Support coordinator will be responsible for completing the RFA and attaching all supporting documentation to support the request in ADIDIS.

- **Steps to Send the RFA:**
  a. SC complete the RFA as trained
  b. Upload the RFA in ADIDIS under the Note Tab for the individual.
     I. Note Type: Attachment
     II. Description: RFA:
     III. **Note:** Please provide brief description of RFA: Example*: RFA request for Additional units for Personal Assistance Community).*
     IV. Attachments: Attach RFA
     V. **Note Recipients: Devin Kennedy- Byron White- Teresa Brazile- SC Supervisor**
  c. Save and Close Note
  d. Send an Email to the same Note Recipients indicating RFA for individual has been placed in ADIDIS. Ensure the email identifies the individual name.
  e. The RFA will be signed by the designated decision-maker (DDM) with the date the decision was determined and uploaded back into ADIDIS tagging all required recipients listed below:
     I. Assigned Support Coordinator (SC who requested the RFA)
     II. SC Supervisor in appropriate Region
     III. CWP Director
     IV. CWP SC Director

ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES
REQUEST FOR ACTION (RFA)

COMMUNITY WAIVER PROGRAM PARTICIPANT INFORMATION

NAME:

ADIDIS CASE NUMBER:

DATE OF BIRTH:

ENROLLMENT GROUP NUMBER:

CURRENT EXPENDITURE CAP:

COUNTY OF RESIDENCE:

PHONE NUMBER:

PROVIDER AGENCY(S) IMPACTED BY THIS RFA:

DATE OF PCP TEAM DISCUSSION LEADING TO THIS RFA:

Select RFA Reason(s)	Reason for RFA	Support Coordinator Submits RFA To:	Recipient of RFA Action/Timeline:
	CSS Consultation	Director of Psychological Services *(And or designee)*	Decision within 5 business day of receiving the processed RFA from the Regional Community Services Specialist IV (RO Evaluator).
	CSS Consultation ***(Crisis Referral)***	Director of Psychological Services	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 and Opportunities and/or Crisis Positive Behavior Supports Before 1st PCP	CWP Director *(And or designee)*	Decision within 2 business days of submitting RFA.
	Exceed Unit Cap for Specific Service	CWP Director *(And or designee)*	Decision within 5 business days of submitting RFA.
	Exceed Expenditure Cap	CWP Director *(And or designee)*	Decision within 15 business days of submitting RFA.
	Request to Transition to Different CWP Enrollment Group	CWP Director *(And or designee)*	Decision within 15 business days of submitting RFA.

SUBMITTED TO:

SUBMITTED BY (SUPPORT COORDINATOR):

NAME OF SUPPORT COORDINATION AGENCY:

DATE SUBMITTED:

REQUEST FOR CSS CONSULTATION? **STOP HERE** AND ATTACH THE **CSS_CONSULTREQUEST-CWP.**

REQUEST FOR SKILLED NURSING AUTHORIZATION? **STOP HERE** AND SUBMIT TO R.O. NURSE.

IS THIS A REQUEST TO EXCEED EXPENDITURE CAP AND/OR UNIT CAP FOR SPECIFIC SERVICE(S)?
IF YES, ANSWER THE FOLLOWING QUESTION, COMPLETE APPROPRIATE SECTION OF THIS FORM (see next page) AND ATTACH A COMPLETED CWP PCP ANNUAL BUDGET SHEET.

LENGTH OF APPROVAL REQUESTED (maximum 1 year):

REQUEST FOR EMERGENCY BREAKS & OPPORTUNITIES SERVICE AND/OR CRISIS POSITIVE BEHAVIOR SUPPORTS SERVICE

DESCRIBE NEED AND JUSTIFICATION FOR REQUEST:

Additional information should be entered on last page of this form.

REQUEST TO EXCEED UNIT LIMIT FOR SERVICE:

Service Name	Type of Limit (e.g., Annual; Weekly; Monthly; Lifetime)	Number of Units Requested Above Limit

DESCRIBE JUSTIFICATION FOR REQUEST TO EXCEED UNIT LIMIT FOR SERVICE(S):
Note if this is one-time or short-term request, rather than ongoing request.
How does the request support specific outcome(s) in the person's PCP?
How does the request address the person's health and safety needs?
Are there specific medical or behavioral needs? If yes, describe.
How does the request support employment, living as independently as possible, community integration/involvement, and/or strong family/friend relationships?
How and how much will natural supports still be assisting the person if approval is granted?
How does the request avoid institutional and/or residential placement?

REQUEST TO EXCEED EXPENDITURE CAP:

Current Expenditure Cap	Total Dollar Amount Requested Above Current Expenditure Cap	How Additional Dollars Will Be Used

DESCRIBE JUSTIFICATION FOR REQUEST TO EXCEED EXPENDITURE CAP:
Note if this is one-time or short-term request, rather than ongoing request.
How does the request support specific outcome(s) in the person's PCP?
How does the request address the person's health and safety needs?
Are there specific medical or behavioral needs? If yes, describe.
How does the request support employment, living as independently as possible, community integration/involvement, and/or strong family/friend relationships?
How and how much will natural supports still be assisting the person if approval is granted?
How does the request avoid institutional and/or residential placement?

Additional information can be entered on last page of this form.

REQUEST TO TRANSITION TO DIFFERENT ENROLLMENT GROUP:

Current Enrollment Group	Enrollment Group Requested	Reason for Transition to New Enrollment Group (*If aging out of current enrollment group, state this and STOP HERE*)

IF REQUESTING ENROLLMENT GROUP #4, PROVIDE THE FOLLOWING ADDITIONAL INFORMATION:
ATTACH CWP PCP ANNUAL BUDGET SHEET FOR CURRENT ENROLLMENT GROUP
Describe all steps taken and efforts made to try to avoid transition to Group #4.
Describe needs (not wants) justifying transition to Group #4.
How does the request address the person's health and safety needs?
Are there specific medical or behavioral needs? If yes, describe.
How does the request avoid institutional placement, homelessness, incarceration, in-patient admission, etc?
How does the request support specific outcome(s) in the person's PCP?
How does the request support employment, living as independently as possible, community integration/involvement, and/or strong family/friend relationships?
How and how much will natural supports still be assisting the person if approval is granted?

DOCUMENTATION OF DECISION & RATIONALE FOR DECISION:

☐ APPROVED ☐ DENIED ☐ INCOMPLETE

IF INCOMPLETE, DESCRIPTION OF ADDITIONAL INFORMATION NEEDED:

______________________________ ______________________________

DECISION-MAKER NAME DECISION-MAKER TITLE

____

DATE OF DECISION

Please use for additional information

ADMH – Division of Developmental Disabilities	Medicaid HCBS Settings Rule Ongoing Monitoring Individual Experience Assessment Survey (IEA)

Section A: General Information - A response to each question is required unless otherwise indicated.

1. Person's First and Last Name:	Date of Survey:
2. Does the person have a legal guardian? **If no, skip to question 4. If yes, answer 3a – 3c** A guardian is a qualified person appointed by a court to act for an incapacitated person only to the extent necessitated by the incapacitated person's mental and adaptive limitations or other conditions warranting the court-appointment of a guardian.	☐ Yes ☐ No
3. If yes, is the guardian a paid/corporate guardian (i.e., the guardian is an attorney or works for an agency), or an unpaid family/friend?	☐ Paid Guardian ☐ Unpaid Guardian
a. If Unpaid Guardian, enter the name of the Guardian	
b. If Paid Guardian, Enter the name of the Guardian/Agency	
c. Does the person live with the legal guardian? ☐ Yes ☐ No	
4. In which Waiver is person enrolled (select one): ☐ CWP Waiver ☐ ID Waiver ☐ LAH Waiver	
5. Name of Support Coordinator Conducting IEA:	
Support Coordinator employed by:	
Number of months SC has supported person:	6. Region (circle one): 1 2 3 4 5
7. If the person is not able to answer one or more of the questions independently, is someone other than the person responding? If **NO** skip to Section B If **YES,** answer 7a – 7b	☐ Yes ☐ No
7a. If yes, what is the First and Last name of the person assisting with responses?	
7b. What is his/her relationship to the person?	☐ Child ☐ Spouse/Partner ☐ (Other)Family ☐ Friend ☐ DSP ☐ Guardian

****IMPORTANT: The person should always be asked first and the person's responses should always be used first.****

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

Question:	Response:	HCBS Setting Requirement:
1.Do you have your own bank account?	☐ Yes ☐ No	*Allows person to control personal resources.*
2.Do you have access to your money?	☐ Yes ☐ No	
3.Can you buy the things you need?	☐ Yes ☐ No	
4.Did someone tell you about the services and supports that you are eligible for?	☐ Yes ☐ No	*Facilitates personal choice regarding services and supports and who provides them.*
5.Did you choose the services and supports you are receiving from the list of services you are eligible for?	☐ Yes ☐ No	
6.If you have services in your person-centered plan that can be self-directed, were you given the option to choose between using self-direction and using a provider agency?	☐ Yes ☐ No ☐ N/A	
7. If you chose an agency provider for some of your services, were you given a choice of provider agency?	☐ Yes ☐ No ☐ N/A	
8. Did you choose the specific person/people who provide your services and supports?	☐ Yes ☐ No	
8.Do you know how to request a change in your services and supports?	☐ Yes ☐ No	
9.Do you know how to request a change in who provides your services and supports?	☐ Yes ☐ No	

Question	Response	Requirement
10. Do you have a paid job?	☐ Yes ☐ No	*Provides opportunities to seek employment and work in a competitive integrated workplace.*
11. Do you think you might want a paid job?	☐ Yes ☐ No	
13. Do you have the help you need to look for a job if and when you want one?	☐ Yes ☐ No	
14. Can you go where you want and like to go in your local the community?	☐ Every time I want to ☐ Most of the time I want to ☐ Not as much as I would like	*Support full access to the broader community.*
15. Does someone regularly tell you about activities and events in your local community that you might be interested in?	☐ Yes ☐ No	
16. Do you have access to transportation if you need to get somewhere in your community?	☐ Every time I want to ☐ Most of the time I want to ☐ Not as much as I would like	
17. Are you able to get the support you need to do things in the community that you want to do?	☐ Every time I want to ☐ Most of the time I want to ☐ Not as much as I would like	
18. Do you do things in your community a few times every week? (Examples: go shopping, church, sports, events, see family and friends, volunteer, work, etc.)	☐ Yes ☐ No	
19. Other than family or paid caregivers, how often each week do you spend time with people who do not have disabilities?	☐ Less than 2 times/week ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times/week	
20. How long have you lived in your current residence?	Choose one: ☐Weeks ☐Months ☐Years	
21. Did you choose where you live?	☐ Yes ☐ No	*The setting was selected by the person from among setting options, including non-disability specific settings.*
22. If you are an adult and don't live in your own home/apartment, has anyone asked you if might like to do this (with support services)?	☐ Yes ☐ No	
23. Did you choose the places where you receive all of your services outside the home?	☐ Yes ☐ No	
24. Do you have access to a phone, computer, or other technology you can use in your home and to communicate with others?	☐ Yes ☐ No	*Optimizes personal initiative, autonomy, and independence in making life choices.*
25. Do you get asked to make some choices for yourself every day?	☐ Yes ☐ No	
26. Can you make decisions about your schedule, where you go, who you see, and when?	☐ Yes ☐ No	

Question	Response	HCBS Setting Requirement
27. Can you be alone if you want to?	☐ Yes ☐ No	*Ensures person's rights of privacy, dignity, respect and freedom from coercion and restraint.*
28. Can you have a private conversation without others listening?	☐ Yes ☐ No	
29. Is your personal information kept secure so others can't see it?	☐ Yes ☐ No	
30. Do the people who support you treat you the way you want to be treated?	☐ Yes ☐ No	
31. Do the people who support you listen to your questions or concerns?	☐ Yes ☐ No	
32. Does anyone ever physically restrain you or limit your freedom to move around?	☐ Yes ☐ No	
33. Do others knock before entering your bedroom?	☐ Yes ☐ No	

Does the person participate in Residential Services? If YES, complete Section C; If NO, STOP HERE.		☐ YES or ☐NO
Section C: Residential Services (Community-Based Residential Services or Adult Family Home Services)		
Select the type of residential services the person is receiving		☐ CWP CBRS ☐ CWP AFH ☐ID Waiver Residential Hab
Name of Service Provider	City/County:	
Question:	Response:	HCBS Setting Requirement:
9. Were you given the option to explore the possibility of living in your own place - a place that is not owned or controlled by a service provider?	☐ Yes ☐ No	*Choice of non-disability specific setting.*
10. Do you know how to request to live someplace else?	☐ Yes ☐ No	*Choice of residential setting.*
11. Do you have a lease that was explained to you and that you signed?	☐ Yes ☐ No	*Specific unit or dwelling is owned, rented or occupied under a legally enforceable agreement.*
12. Do you know your rights as a tenant and how you are protected from eviction?	☐ Yes ☐ No	
13. Can you lock and unlock your front door yourself?	☐ Yes ☐ No	
14. Are you comfortable with who else has a key to your front door?	☐ Yes ☐No	*Unit has lockable entrance door person has key and who else has key is limited to only staff that need to.*
15. Do others knock before entering your front door?	☐ Yes ☐ No	
16. Can you close and lock your bedroom door?	☐ Yes ☐ No	*Each person has privacy in their sleeping or living unit.*
9. Can you close and lock your bathroom door?	☐ Yes ☐ No	
10. Are you comfortable with who else has a key to your bedroom or bathroom?	☐ Yes ☐ No	
11. Were you given the option of a private room if you could afford it?	☐ Yes ☐ No	

12. Did you choose your roommate?	☐ Yes ☐ No	*Choice of housemate(s) and roommate.*
13. Do you like living with your roommate?	☐ Yes ☐ No	
14. Do you know how to request a roommate change?	☐ Yes ☐ No	
15. If you want to share your bedroom, can you choose who to share with?	☐ Yes ☐ No	
16. Did you decorate or help decorate the place you live (paint colors; wall hangings; furniture)?	☐ Yes ☐ No	*Freedom to furnish and decorate.*
17. Did you choose how to have your room decorated (paint color; wall hangings; furniture)?	☐	
18. Can you move the furniture where you want?	☐ Yes ☐ No	
19. Can you hang up different things on the wall if you want to?	☐ Yes ☐ No	
20. Do you make your own schedule?	☐ Yes ☐ No	*Freedom and support to control schedules and activities.*
21. Can you decide when you get up, take a bath, eat, exercise or participate in other activities at home and in the community?	☐ Yes ☐ No	
22. Do you receive supports to participate in the community?	☐ Yes ☐ No	
23. Can you watch television, listen to the radio and do things that you like when you want to?	☐ Yes ☐ No	
24. Can you eat when you want to?	☐ Yes ☐ No	*Access to food at any time.*
25. Can you eat where you want to?	☐ Yes ☐ No	
25. Can you eat what you want to?	☐ Yes ☐ No	
26. Can you request a different meal if you want one?	☐ Yes ☐ No	
27. Are snacks accessible and available anytime?	☐ Yes ☐ No	
28. Can you have visitors?	☐ Yes ☐ No	*Allow visitors at any time.*
29. Can you have visitors at any time?	☐ Yes ☐ No	
30. Can you have privacy with your visitors if you want to?	☐ Yes ☐ No	
31. Do you have the supports you need to move around your room/house as you choose?	☐ Yes ☐ No	*Physically accessible.*
32. Can you enter and exit your room/house as you choose?	☐ Yes ☐ No	
33. Do you have full access to the common areas of your home such as the kitchen, dining area, laundry, and shared living areas?	☐ Yes ☐ No	
34. Have you been given a resident handbook? (If applicable)	☐ Yes ☐ No ☐ N/A	*Policies outlining personal rights are available and accessible to the person.*
35. Do you understand the handbook or know who to ask if you have questions?	☐ Yes ☐ No ☐ N/A	
36. Do you have access to a phone, computer or other technology to communicate with others outside the home?	☐ Yes ☐ No	

37. Can you make decisions about your schedule, where you go, who you see, and when?	☐ Yes ☐ No	*Optimizes personal initiative, autonomy, and independence in making life choices.*

Revisions to Person Centered Plan Required: ☐ Yes ☐ No *If yes, describe areas to be addressed and target date for revisions to be done.*

Signature of Support Coordinator:	Date forwarded to: ☐ CWP QE Staff (for CWP Participants) ☐ Regional Office Monitoring Staff (for ID/LAH Participants)

TO BE COMPLETED BY CWP QE STAFF OR REGIONAL OFFICE MONITORING STAFF

Remediation Plan Required: ☐ Yes ☐ No *If yes, complete table below*

Remediation Steps Required:	**Who Responsible?** ***Name HCBS provider(s) and/or Support Coordinator as applicable***	**Target Date for Completion of Each Remediation Step:**

☐ Check here when QE Staff/RO Monitor confirm remediation fully completed DATE CONFIRMED:	**Signature of QE Staff/Regional Office Monitoring Staff:**

Community Waiver Program (CWP) Freedom of Choice:
To Be Completed by the Person and/or Legal Guardian/Appointed Representative with Assistance from The Support Coordinator

Participant Name: ____ Date: _________________

The checkboxes and signature on this form attests that the person and/or the legal guardian/appointed representative[2] has: (1) received an explanation of the available Alabama Medicaid Home and Community-Based Services (HCBS) waiver for persons with intellectual disabilities, including information on the option to self-direct waiver services and/or choose a provider from the list of enrolled HCBS waiver-credentialed service providers; (2) agreed to the waiver applicant's responsibilities; and (3) received an explanation that the HCBS waiver is offered as an alternative to the choice of an institutional Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID) placement.

I. HCBS Waiver Services Available

A. ☐ I have received information on services available in the Community Waiver Program (CWP) which is the Home and Community-Based (HCBS) waiver available to me.

B. ☐ I understand I have the right to receive the services in my Person-Centered Plan (PCP) in settings that are non-disability specific (not designed specifically for people with disabilities) and I understand that during the Person-Centered Planning process, I will be offered the choice to receive each of my services in settings not designed specifically for people with disabilities.

II. Option to Self-Direct Services and/or Choose Certified Service Providers if Enrolled in HCBS Waiver

A. ☐ I have received an explanation of Community Waiver Program (CWP) services that can be self-directed and how self-direction works.

B. ☐ I understand I have the option to self-direct some or all of the services in my Person-Centered Plan (PCP) that can be self-directed, or I can choose from available, credentialed service provider agencies.

III. Choice to Receive HCBS Waiver (Please Check Only One)

☐ I understand that enrollment in a Home and Community-Based Services (HCBS) waiver is strictly voluntary.

CHOOSE ONLY ONE:

1. ☐ At this time, I choose to receive Home and Community-Based Services (HCBS) by enrolling in the Community Waiver Program (CWP).
2. ☐ At this time, I do not choose to receive Home and Community-Based Services (HCBS) through the Community Waiver Program (CWP). I understand that I have a choice to select

waiver services at a future point if I am determined eligible at that time and the Community Waiver Program (CWP) enrollment group for which I am eligible is not at full capacity.

IV. Applicant's Responsibilities if HCBS Waiver is Selected

A. ☐ I understand the Home and Community-Based (HCBS) waiver will deliver services according to my Person-Centered Plan (PCP). I will cooperate in annual reassessment when my PCP is due for redetermination or when my life circumstances change.

B. ☐ I understand that my Person- Centered Plan (PCP) will be monitored and reviewed by my Support Coordinator, and I agree to participate in necessary meetings and interviews with my Support Coordinator when requested. I understand I can contact my Support Coordinator at any time I have questions about my PCP or the services that I receive.

V. Freedom of Choice and Notice of Fair Hearing (explanation of rights under 42 CFR Part 431, Subpart E)

A. ☐ I elect to participate in the Community Waiver Program (CWP) and receive Home and Community-Based Services (HCBS) as an alternative to placement in an institutional (ICF/IID). I understand that I may withdraw from the Community Waiver Program (CWP) at any time and that my participation in the CWP will not restrict my access to ICF/IID placement in the future.

B. ☐ I understand that if I am not allowed to make my own decision about whether to use institutional (ICF/IID) or Home and Community-Based Services (HCBS) waiver services, I can request a Fair Hearing and the Support Coordinator may assist with that process.

VI. Freedom of Choice Signatures

____ ____________________

Participant: Date:

____ ____________________

Legal Guardian/ Appointed Representative: Date:

____ ____________________

Support Coordinator Signature: Date:

Freedom of Choice Complaint/Grievance and Fair Hearing Process

As a person opting to enroll in a Home and Community-Based Services (HCBS) Waiver, you also have the right to request institutional services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). If you feel you have not been allowed to make your own decision about whether to use institutional (ICF/IID) or HCBS Waiver services, you have the right to file a formal complaint/grievance verbally or in writing, to have your complaint/grievance thoroughly and adequately investigated, and to request a Fair Hearing to have resolution brought to your complaint/grievance through adequate due process. The following agencies are available to investigate your complaint/grievance and respond to your request for a Fair Hearing.

Region I Community Services, Decatur, AL	(256) 898-2789
Region II Community Services, Tuscaloosa, AL	(205) 554-4302
Region III Community Services, Mobile, AL	(251) 283-6200
Region IV Community Services, Wetumpka, AL	(334) 676-5565
Region V Community Services, Birmingham, AL	(205) 916-7800
ADMH Division of Intellectual Disabilities	(334) 242-3701
ADMH Office of Advocacy Services	1-800-367-0955
Alabama Disabilities Advocacy Program (ADAP)	1-800-826-1675

It is suggested that you file your complaint/grievance with your local Regional Community Services Office first. However, you may choose to go directly to the Division of Developmental Disabilities, Office of Advocacy Services, ADAP, or call them at any time during the complaint/ grievance process if you are not satisfied.

Community Waiver Program (CWP)
Request for Proposal (RFP) to Provide Waiver Services

Reply by:

Reply to:

CWP Enrollee:

Living Situation:

Natural Supports/ Family:

Communication:

Strengths/Interests/Preferences/Passions:

Outcomes/ Goals:

Services Requested:

Outcomes/Goals:	Service	Unit / # of Units / Unit Rate	Total Cost

Physical abilities and challenges; mobility skills (note adaptive/medical equipment if applicable):

Mental health status including positive supports that work to avoid incidents/crises; note whether BSP exists for person or is being developed:

Self-care skills:

Formal diagnoses other than ID (physical; psychiatric; medical) and medications 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):

Other CWP services the person is receiving or will soon begin receiving:

Request for CSS Consultation for CWP Participant or Individual in Process of Enrollment in CWP

Date of request ______________________

Name of Person for whom services requested ______________________________________

Date of Birth: Gender: ADIDIS #

Region: County where residing currently:

Legal Status/Guardian or Medicaid Representative (if applicable) & phone

____

Request from (name) : Phone:

Agency ____

Service(s) requested: ____

Reason for Request: (Symptoms of Concern / Problem Behaviors / Referring Complaint)

(also identify any other sources from whom you attempted to seek consultation services)

____

____

____

____

Current or most recent (include phone number):

Physician ____

Psychiatrist ____

Dentist ____

List currently involved service providers or, if none, most recently involved prior service providers (hospital, skilled nursing facility, youth detention center, behavioral/mental health center, residential program, DHR, foster care system, etc.) and contact information:

____

____

____

Is there any suspicion that the person is in pain?

____

____

List all medications, including over-the-counter medications, vitamins, and supplements currently prescribed:

____

____

____

____

____

Current:

Home Address ____ Phone _________________

Home provider agency (if applicable): ____

Home provider agency contact person name:

Phone __________________________ e-mail ______________________________________

Support Coordinator ____

Agency ____

Address ____

Phone ___________________________ e-mail ____________________________________

Attach Support Coordinator's most recent Face-to-Face Report if enrolled >1 month.

Attach current Behavior Support Plan (BSP) if available.

Completed by: ___________________________________ Date: _______________________________

Rental or Residency Agreement
Guidelines

In accordance with CMS regulations 42 CFR 441.301 (c) (4) (vi), Landlords/Providers must have a lease or other legally enforceable written agreement providing protections for Tenants/Individuals receiving HCBS Waiver services in provider owned and controlled settings certified by ADMH. Such agreements may take the form of a Rental or Residency Agreement that ensures Tenants/Individuals receiving HCBS Waiver services in provider owned and controlled settings are provided the same protections afforded others under Alabama Tenant Laws, including protections from eviction. The following guidelines shall be followed to ensure a Rental or Residency Agreement complies with CMS regulations.

RENTAL OR RESIDENCY AGREEMENT

The Residential/Residency Agreement must include the following:

1. The individual's/tenant's or legal guardian's name, if applicable, and the landlord's/provider's name for whom the agreement is being entered.

2. The location/address of the property subject to the agreement.

3. Period for which the agreement is binding.

4. The specific monthly rent or room and board to be paid by the individual/tenant.

5. The pro-rated rate for partial month occupancy based on move-in or move-out date.

6. The specific services and supports to be provided in exchange for payment of rent or room and board (e.g., utilities, meals, laundry, etc.)

7. Date by which monthly rent or room and board payment is due and specific penalty, if any, for late payment.

8. The specific conditions under which the rental or room and board rates can be changed. (Note the Landlord/Provider must give the tenant/individual or Legal Guardian, if applicable, at least 30 days prior notice of any rate increase and amend the written agreement to reflect the new rate)

9. The Landlord's/Provider's refund policy in instances of Tenant's/Individual's hospitalization, death, transfer to a nursing facility or other health care facility and/or tenant's/individual's voluntary or involuntary permanent move from the residence.

10. The Landlord's/Provider's policy regarding pets or service animals on property.

11. The Landlord's/Provider's eviction policy or involuntary termination of residency agreement. (Note such must be compliant with applicable Alabama Landlord Tenant Act)

12. If the Landlord/Provider determines that they no longer can provide Residential services to a tenant/individual, or the landlord/provider follows requirements of Alabama landlord/tenant law relating to eviction as required, the tenant/individual may be required to move. In this event, the tenant/individual will receive advanced notice and have the right to appeal the decision. In the event the individual chooses to initiate an

appeal, the landlord/provider may not terminate the Residential services until the appeal process is fully complete and then only if the decision was decided in the landlord/provider's favor. The following steps must occur if the landlord/provider proposes to terminate services:

A. The landlord/provider will notify the individual or legal representative, the ADMH Regional Office, and the Support Coordinator, in writing, of the intended service termination.

B. The notice will be provided at least 30 days before the proposed effective date of service termination.

C. The written notice of a proposed service termination will include all of the following elements:

IV. The reason for the action.
V. A summary of measures taken to minimize or eliminate the need for service termination, and why these measures failed to prevent the termination (this element will not be required when service termination is a result of the program ceasing operation).
VI. The individual's right to appeal the termination of services.

13. The Rental or Residency Agreement must contain the signatures of both the Landlord/Provider and Tenant/Individual and Date of Signatures.

Note: The above Rental or Residency Agreement must be presented to the Tenant/Individual in language and terms which the Tenant/Individual or Legal Guardian, if applicable, understands.

Rights and Responsibilities Agreement

The Rights and Responsibilities Agreement may be included as a section of the Rental or Residential Agreement or must be in a separate agreement. This agreement must include all Rights as afforded those receiving HCBS Waiver services under CMS Regulations 42 CFR 441.301 (c) (2) (xiii) and CFR 441.503 (a) (1) (vi) (F). The following must be included to comply with CMS regulations:

4. The tenant's/individual's or legal guardian's name, if applicable, and the landlord's/provider's name for whom the agreement is being entered into.
5. Tenant's/Individual's Responsibilities to maintain his/her living space and not engage in activities that may disrupt or potentially cause harm to other individuals/tenants.
6. Tenant's/Individual's Rights to:
    - Live under a legally enforceable agreement with protections substantially equivalent to landlord/tenant laws of the State of Alabama and other applicable laws or rules of the county, city or other designated jurisdiction in which the individual resides.
    - Privacy in their sleeping/living unit; including the right to have entrance doors lockable with individual and only appropriate staff having access to keys. (Note that staff's access to bedroom

is limited to situations as described in the residency agreement and to emergencies where the health/safety/well-being of the occupants is jeopardized.

- Choice of roommates for individuals sharing units or bedrooms.
- Freedom to furnish and decorate their living and sleeping areas as long as decorations do not damage the unit. (Note that in common areas of shared living arrangement, tenants/individuals are expected to collaborate with their housemates/roommates.)
- Freedom and support to control their own schedules and activities.
- Freedom and support to have access to food at any time unless restricted due to modifications in the person-centered plan. (Note that such modifications can include restrictions due to individual's/tenant's personal health, financial plan as included in the person-centered plan and/or exhaustion of board/food allowances as included in the lease/rental agreement)
- Have visitors of their choice at any time. (Note that supports may be needed to protect the rights and privacy of others living in the home)
- Control over Personal Resources, including access and management of their personal funds.

4. There shall be no modifications of the right to live under a legally enforceable agreement as described above. Modifications to any of the other rights articulated above may only occur when a condition presents a significant risk to the individual's health and/or safety that is supported by specific assessed need, justified in the individual's Person-Centered Plan and compliant with all ADMH-DDD Due Process Procedures.

5. The signatures of both the Landlord/Provider and Tenant/Individual and Date of Signature.

Note: The Rights and Responsibilities Agreement must be presented to the Tenant/Individual in language and terms which the Tenant/Individual or Legal Guardian, if applicable, understands.

ADMH Approved: ___________________________________ Date: 2/10/2023

ADMH DDD

Community Waiver Program (CWP) Provider Application

DEMOGRAPHICS

Organization Name: ______________________________

☐ Name Change ______________________________

Organization Address: ______________________________

Organization FEIN: ______________________________

Organization Email: ______________________________

STAARS Vendor # ______________________________

NPI # ______________________________

Phone: ______________________________

Website: ______________________________

Executive Director: Name: ______________________________

Phone: ______________________________

Email: ______________________________

Type of Ownership ☐ Non-Profit

☐ For Profit

☐ Public

Are you a current provider? ☐ Yes If Yes ☐ ID ☐ LAH

☐ No

Would you like your program to be considered for another waiver?* If Yes ☐ ID ☐ LAH

* Consideration for another waiver is not a guarantee of acceptance or approval.

What county or counties will your program serve?

Provide:

☐ Business License (if applicable)

☐ Professional License (Physical, Occupational, and Speech and Language Therapy)

☐ Articles of Incorporation (non-profits)

☐ W-9

Select the services that your agency is requesting to provide.

☐ **Adult Family Home**

☐ **Assistive Technology and Adaptive Aids**

☐ **Breaks and Opportunities – Respite**

☐ **Community Integration Connection and Skills Training**

☐ **Community Transportation**

☐ **Community-Based Residential Services**

☐ **Employment Supports – Co-Worker Supports**

☐ **Employment Supports – Individual Employment Support Career Advancement**

☐ **Employment Supports – Individual Employment Support Discovery**

☐ **Employment Supports – Individual Employment Support Exploration**

☐ **Employment Supports – Individual Employment Support Job Coaching**

☐ **Employment Supports – Individual Employment Support Job Development Plan**

☐ **Employment Supports – Individual Employment Support Job Development**

☐ **Employment Supports – Integrated Employment Path**

☐ **Employment Supports – Small Group Support**

☐ **Family Empowerment and Systems Navigation Counseling**

☐ **Financial Literacy and Work Incentives Benefits Counseling**

☐ **Housing Counseling**

☐ **Housing Start-up Assistance**

☐ **Independent Living Skills Training**

☐ **Minor Home Modifications**

☐ **Occupational Therapy**

☐ **Peer Specialist Services**

☐ **Personal Assistance Community**

☐ **Personal Assistance Home**

☐ **Physical Therapy**

☐ **Positive Behavioral Supports**

☐ **Remote Supports Backup Contractor**

☐ **Remote Supports Contractor**

☐ **Skilled Nursing**

☐ **Speech and Language Therapy**

☐ **Support Coordination**

☐ **Supported Living Services**

SIGNATURE SECTION

	Click or tap to enter a date.
CEO/ED	Date

ADMH DDD

Community Waiver Program (CWP)
Service Proposal

DEMOGRAPHICS

Organization Name: ______________________________

Organization Address: ______________________________

Organization FEIN: ______________________________

Organization Email: ______________________________

STAARS Vendor # ______________________________

Phone: ______________________________

Website: ______________________________

Executive Director: Name: ______________________________

Phone: ______________________________

Email: ______________________________

Type of Ownership ☐ Non-Profit

☐ For Profit

☐ Public

Are you a current provider? ☐ Yes If Yes ☐ ID ☐ LAH

☐ No

What county or counties will your program serve?

Provide:

☐ Business License (if applicable)

☐ Professional License (Physical, Occupational, and Speech and Language Therapy)

☐ Articles of Incorporation (non-profits)

☐ W-9

Select the services that your agency is requesting to provide.

- ☐ **Adult Family Home**
- ☐ **Assistive Technology and Adaptive Aids**
- ☐ **Breaks and Opportunities – Respite**
- ☐ **Community Integration Connection and Skills Training - Connections**
- ☐ **Community Integration Connection and Skills Training – Skills**
- ☐ **Community Transportation**
- ☐ **Community-Based Residential Services**
- ☐ **Employment Supports – Co-Worker Supports**
- ☐ **Employment Supports – Individual Employment Support Career Advancement**
- ☐ **Employment Supports – Individual Employment Support Discovery**
- ☐ **Employment Supports – Individual Employment Support Exploration**
- ☐ **Employment Supports – Individual Employment Support Job Coaching**
- ☐ **Employment Supports – Individual Employment Support Job Development Plan**
- ☐ **Employment Supports – Individual Employment Support Job Development**
- ☐ **Employment Supports – Integrated Employment Path**
- ☐ **Employment Supports – Small Group Support**
- ☐ **Family Empowerment and Systems Navigation Counseling**
- ☐ **Financial Literacy and Work Incentives Benefits Counseling**
- ☐ **Housing Counseling**
- ☐ **Housing Start-up Assistance**
- ☐ **Independent Living Skills Training**
- ☐ **Minor Home Modifications**
- ☐ **Occupational Therapy**
- ☐ **Peer Specialist Services**

- ☐ **Personal Assistance Community**
- ☐ **Personal Assistance Home**
- ☐ **Physical Therapy**
- ☐ **Positive Behavioral Supports**
- ☐ **Remote Supports Backup Contractor**
- ☐ **Remote Supports Contractor**
- ☐ **Skilled Nursing**
- ☐ **Speech and Language Therapy**
- ☐ **Support Coordination**
- ☐ **Supported Living Services**

SIGNATURE SECTION

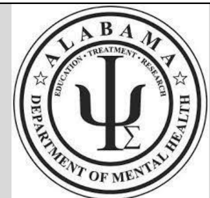
______________________________	Click or tap to enter a date.
CEO/ED	Date

CWP PLAN FOR ALIGNMENT

Provider:		Date:		CWP Service:	

All performance indicators in Need of Action require a Plan for Alignment

Performance Indicator	Action Steps	Due Dates	Responsible Person(s)	Evidence of Success	Alignment Achieved P&Q Initials and Date



CWP PLAN FOR EXCELLENCE

Provider:		Date:		CWP Service:	
Performance Indicator	**Quality Enhancement Action Steps**	**Due Dates**	**Responsible Person(s)**	**Evidence of Enhanced Quality**	**Enhancement Achieved P&Q Initials and Date**

Activity: Administrative Functions Visit

Provider Name:		Date:	
Quality Enhancement Staff Name:		Time Spent Together (in minutes):	
Confirmed PPQ Score at Today's Visit:		Confirmed Minimum Qualifications to Continue CQP service(s):	
Strengths of the Visit:			
Challenges of the Visit:			
Opportunities of the Visit:			
CWP Services Authorized to Provide:			
Reviewed Activities for Visit #7:		Date for Visit #7:	
Dates Scheduled for Targeted Conversations and Focus Groups:			
People Served By the Organization:		Direct Support Professionals:	
Family members/guardians of people supported by the organization:		Front-Line Supervisors (If applicable):	

Targeted Conversation(s) Summary:

Focus Group(s) Summary:

Summary of Visit:			
Meets	0	Needs Action	0
Exceeds	0	Needs 90 Day Action	0

Plan(s) for Alignment

Performance Indicator	Action Steps	Due Dates	Alignment Achieved
Number and Content	1) First Step	12/31/2022	No
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0

Plan(s) for Excellence			
Performance Indicator(s)	**Quality Enhancement Action Steps**	**Due Dates**	**Enhanceme nt Achieved**
Number and Content	1) First Step	12/31/2022	No
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0

Good Standing

A Community Waiver Program (CWP) provider is considered in good standing as long as they participate fully in the credentialing process, which is defined as:

- Actively participating in monthly visits
- Providing necessary and requested documentation in a timely manner
- Developing and completing required plans
- Providing adequate evidence of their alignment with CWP qualified provider requirements

If any of the above cease to occur, a process will be initiated to withdraw the provider's credentials and the provider will no longer be considered a provider in good standing that is authorized to continue participation in the Community Waiver Program.

The signatures below indicate that based on the activities from today's visit the provider is currently considered to be in good standing.

Provider Representative Signature:	
Quality Enhancement Staff Signature:	

Activity: Communications Visit

Provider Name:		Date:	
Quality Enhancement Staff Name:		Time Spent Together (in minutes):	
Confirmed PPQ Score at Today's Visit:		Confirmed Minimum Qualifications to Continue CQP service(s):	
CWP Services Authorized to Provide:			
Strengths of the Visit:			
Challenges of the Visit:			
Opportunities of the Visit:			
Reviewed Activities for Visit #5:		Date for Visit #5:	

Dates Scheduled for Targeted Conversations and Focus Groups:

People Served By the Organization:		Direct Support Professionals:	
Family members/guardians of people supported by the organization:		Front-Line Supervisors (If applicable):	

Targeted Conversation(s) Summary:

Focus Group(s) Summary:

Summary of Visit:

Meets	0	Needs Action	0
Exceeds	0	Needs 90 Day Action	0

Plan(s) for Alignment

Performance Indicator	Action Steps	Due Dates	Alignment Achieved
Number and Content	1) First Step	12/31/2022	No
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0

Plan(s) for Excellence			
Performance Indicator(s)	**Quality Enhancement Action Steps**	**Due Dates**	**Enhancement Achieved**
Number and Content	1) First Steps	12/31/2022	No
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0

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The signatures below indicate that based on the activities from today's visit the provider is currently considered to be in good standing.

Provider Representative Signature:	
Quality Enhancement Staff Signature:	

Activity: Staffing Visit

Provider Name:		Date:	
Quality Enhancement Staff Name:		Time Spent Together (in minutes):	
Confirmed PPQ Score at Today's Visit:		Confirmed Minimum Qualifications to Continue CQP service(s):	
Strengths of the Visit:			
Challenges of the Visit:			
Opportunities of the Visit:			
CWP Services Authorized to Provide:			
Reviewed Activities for Visit #3:		Date for Visit #3:	
Dates Scheduled for Targeted Conversations and Focus Groups:			
People Served By the Organization:		Direct Support Professionals:	
Family members/guardians of people supported by the organization:		Front-Line Supervisors (If applicable):	

Targeted Conversation(s) Summary:			
Focus Group(s) Summary:			
Summary of Visit:			
Meets	0	Needs Action	0
Exceeds	0	Needs 90 Day Action	0
Plan(s) for Alignment			
Performance Indicator	**Action Steps**	**Due Dates**	**Alignment Achieved**
Number and Content	1) First Steps	12/31/2022	No
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0

Plan(s) for Excellence			
Performance Indicator(s)	**Quality Enhancement Action Steps**	**Due Dates**	**Enhancement Achieved**
Number and Content	1) First Step	12/31/2022	No
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0

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The signatures below indicate that based on the activities from today's visit the provider is currently considered to be in good standing.

Provider Representative Signature:	
Quality Enhancement Staff Signature:	

Activity: Values Visit

Provider Name:		Date:	
Quality Enhancement Staff Name:		Time Spent Together (in minutes):	
Confirmed PPQ Score at Today's Visit:		Confirmed Minimum Qualifications to Continue CQP service(s):	
CWP Services Authorized to Provide:			
Strengths of the Visit:			
Challenges of the Visit:			
Opportunities of the Visit:			
Reviewed Activities for Visit #6:		Date for Visit #6:	

Dates Scheduled for Targeted Conversations and Focus Groups:

People Served By the Organization:		Direct Support Professionals:	
Family members/guardians of people supported by the organization:		Front-Line Supervisors (If applicable):	

Targeted Conversation(s) Summary:

Focus Group(s) Summary:

Summary of Visit:			
Meets	0	Needs Action	0
Exceeds	0	Needs 90 Day Action	0

Plan(s) for Alignment

Performance Indicator	Action Steps	Due Dates	Alignment Achieved
Number and Content	1) First Steps	12/31/2022	No
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0

Plan(s) for Excellence			
Performance Indicator(s)	**Quality Enhancement Action Steps**	**Due Dates**	**Enhancement Achieved**
Number and Content	1) First Steps	12/31/2022	No
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0
0	0	1/0/1900	0

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The signatures below indicate that based on the activities from today's visit the provider is currently considered to be in good standing.

Provider Representative Signature:	
Quality Enhancement Staff Signature:	

Attachment A
Preferred Provider Qualifications

Each Preferred Provider Qualification is weighted on a score from 2 to 5 based on the relevant strength of the indicator in predicting the provider's ability to deliver Community Waiver Program (CWP) services effectively.

- Minimum score to be a Preferred Provider = twelve (12) resulting from a positive score in at least three of the five factors identified below to qualify.
- Exception for providers serving a beneficiary that voluntarily transitions from the ID or LAH waiver into the Community Waiver Program: If the transferring provider does not meet the minimum score of twelve (12), but does score between nine (9) and eleven (11), the transferring provider will have a six-month grace period to achieve a minimum score of twelve (12), resulting from a positive score in at least three of the five factors; but only if the transferring provider contractually agrees to receive technical assistance from the state during the grace period to help the provider achieve the minimum qualifying score. During this grace period, the transferring provider will only be allowed to serve the transferring beneficiary from the ID or LAH waiver. After the grace period, if they successfully achieve the minimum qualifying score to be a preferred provider, as described in Attachment D, they will be permitted to compete and be selected in a subsequent RFP process to serve all Community Waiver Program beneficiaries. Maximum possible score is fifty (50)

I. Experience with Waiver Service Provision

B. The provider currently participates in the ID or LAH Section 1915(c) waiver programs for individuals with ID, and its most recent certification score was 90 percent or higher, placing it on a two-year review cycle. (5)
C. The provider is a contracted provider of HCBS for individuals with ID in another state or the ADMH Autism program. (3)
D. The provider employs or contracts with an appropriately licensed professional(s) in one (1) or more specialty areas (behavioral services, occupational therapy, physical therapy, speech language pathology, orientation and mobility, nurse education, training, and delegation) and this professional's role will involve training and/or consultation with direct support staff employed by the provider in supporting individuals with intellectual disabilities enrolled in the Community Waiver Program as verified by the provider's proposed staffing chart for the Community Waiver Program and the licensed professional's position description(s) or contract(s). (3)

II. Independent Accreditation

B. The provider holds accreditation, or is actively seeking accreditation ("actively seeking" means applied for and paid for accreditation within three months of applying to be part of the Community Waiver Program network) from any of the following nationally recognized accrediting bodies (4):
    1. Commission on Accreditation of Rehabilitation Facilities minimum provisional accreditation
    2. Council on Quality and Leadership (CQL) accreditation in at least one of the following:
        i. Quality Assurance Accreditation,
        ii. Personal-Centered Excellence Accreditation, or
        iii. Person-Centered Excellence w/ Distinction Accreditation

3. Council on Accreditation (COA) accreditation for Private Organization covering, at minimum, services for people with intellectual and developmental disabilities.

C. The provider has obtained Systemic, Therapeutic, Assessment, Resources, and Treatment (START) program certification, START network partner certification, or has at least one staff person who has completed START coordination certification and whose time will be at least 50 percent dedicated to serving referrals from the Community Waiver Program, as verified by the provider's proposed staffing chart for the Community Waiver Program. (3)

III. Support of Person-Centered Service Delivery

A. The provider has demonstrated leadership in assisting individuals with intellectual disabilities to pursue their interests and goals in their local community through community involvement, participation, and contribution, verifiable by documentation of outcomes achieved by individuals with ID (a random sample of 5 percent - minimum 5 persons) served by the organization. (3)

B. The provider has policies and processes in place to support individuals served to exercise choice with regard to direct support staff assigned to work with them; and the provider has a strategic goal (and documented plan with evidence of implementation occurring) to increase the extent to which individuals served have choice with regard to direct support staff assigned to work with them. (3)

C. The provider is willing and able to recruit and provide staff who are linguistically competent in spoken languages other than English when one of these languages is the primary language of individuals enrolled in the Community Waiver Program and/or their primary caregivers, verifiable by provider policy and staff position descriptions/contracts. (2)

D. The provider is willing and able to assign staff that are trained in the use of augmentative communication aids or methods in order to achieve effective communication with individuals enrolled in the Community Waiver Program and/or their primary caregivers, verifiable by provider policy and staff position descriptions/contracts. (2)

IV. Support of Independent Living

A. The provider has documented experience of providing HCBS to individuals with intellectual disabilities in their own homes or family/natural support homes (not owned or leased by a provider of services) and in integrated community settings (not in provider owned or operated non-residential facilities), verifiable by provider policy, existing HCBS contract(s), and service delivery records. (4)

B. The provider has assisted a person(s) supported by the agency in residential services to successfully transition into an independent or supported living arrangement, verifiable by provider policy, case examples and service delivery records. (4)

V. Support of Integrated, Competitive Employment and Community Inclusion

A. The provider has experience assisting individuals with intellectual disabilities to obtain and/or maintain individualized, competitive, integrated employment where an HCBS service provider is not the employer of record. This is evidenced by the provider's data, for a three-month period with an end date within six months of applying to become a Community Waiver program provider, showing the percentage of individuals with intellectual disabilities served (regardless of services provided) who are working in individualized, competitive, integrated employment is at least 15 percent. (4)

B. The provider is a contracted provider for Alabama Department of Rehabilitation Services. (4)

C. The provider can demonstrate relationships with other non-disability specific and non-Medicaid funded community organizations, associations and/or businesses that can be leveraged to assist individuals with ID in pursuing and achieving employment and integrated community involvement

goals, as evidenced by at least three letters of commitment from such community-based organizations to work with the providers in order to help persons supported by the provider to achieve such goals. Three letters of commitment are required per county that the provider is applying to serve through the Community Waiver Program. Letters of commitment from other ID, LAH, CWP, Autism or mental health service providers will not be counted. (4)

D. The provider is a consumer-led organization with a board of directors, more than 50 percent of whom have developmental disabilities. (2)

Financial Management Services Agency (FMSA) Transfer Form: Self-Directed Services (To be completed by Person, Parent/Guardian, and Support Coordinator)			
Waiver Participant Name:	Medicaid Number:	Authorization ID:	EIN#:
Support Coordination Supervisor:	Support Coordinator:	HCBS Waiver:	
Employer of Record Name:	Date:	Region:	

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. Self-direction is a model of service delivery in which an individual has maximum choice and control over how, when, where, and from whom their services and supports are provided.

	Please check Yes or No indicating your agreement with and acknowledgment of the following:		
1	I have received information regarding the option to self-direct my services as well as information for certified support service agencies.	YES	NO
2	I understand that I have the right to choose the provider for each of my HCBS Waiver services.	YES	NO
3	I have received and read ALLIED brochure for FMSA.	YES	NO
4	I have received and read Public Partnerships LLC (PPL) brochure for FMSA.	YES	NO
5	I understand my Roles and Responsibilities in receiving Self-Directed Services through each FMSA.	YES	NO
6	I am making a Voluntary Decision to transfer **From _____________To ________________** **Targeted Effective Date:_________________**		
7	I understand that the FMSA transfers are allowed only at the start of the quarter **(January 1st, April 1st, July 1st, October 1st)** and <u>only once per year</u> (due to federal tax regulations).	YES	NO

I understand that due to the transfer process the budgetary savings will not be accessible for 60 days.
My signature below is my acknowledgement and agreement to transfer FMSA.

Waiver Participant Signature________________________________ Date_____________

Employer of Record Signature_______________________________ Date_____________

ADMH Representative Signature_____________________________ Date_____________

Community Waiver Program:
Deciding if Self-Direction is Right for You

What is Self-Direction?

- A way to receive Community Waiver Program services and supports where you are in control
- Self-direction is based on the idea that people with disabilities know their needs best and should lead decision-making about things that affect their lives
- You choose your own workers who support you
- You decide when and how you will receive the services your workers provide

What are my responsibilities?

- Deciding what CWP services and supports you want to purchase
- Choosing who works for you
- Managing your workers

Is self-direction right for me?

People decide to self-direct for a lot of different reasons, including:

- Wanting more control over their services and staff
- Wanting to purchase items with CWP dollars
- Not feeling satisfied with their current services
- Wanting to hire someone they know as a paid caregiver

More than 1 million Americans now self-direct their services.

Community Waiver Program:
Deciding if Self-Direction is Right for You

For the support coordinator to read aloud to the participant: Self-direction is an option that offers you more choice and control over the services and supports you need to live at home. You are able to find, choose and hire your own workers rather than use a provider agency that chooses and hires your workers. The purpose of this tool is to see if you are interested in directing your services and hiring your own workers.

Keep in mind, not all CWP services can be self-directed. If you have services in your plan that can be self-directed, you can choose to self-direct some of these services but not all of them. Or you can choose to self-direct all of the services in your plan that can be self-directed.

I will read aloud a few questions. You will answer most questions with “yes”, “no”, or “yes, with help”.

- “Yes” means you can and are willing to perform the task.
- “No” means you can’t or are not willing to perform the task.
- “Yes, with help” means you can do the task if you have help from someone you trust.

1. Why does self-direction sound good to you? *(Note: this question should be open-ended.)*
2. Are you willing to find and hire your own workers? ☐ Yes ☐ No ☐ Yes, with help
3. Do you know how you would find a worker? (For example, where would you look, would you place an ad, and how you would interview them?) ☐ Yes ☐ No ☐ Yes, with help
4. Can you explain the support you need and how your worker should help you? ☐ Yes ☐ No ☐ Yes, with help
5. Can you fill out the required paperwork to make sure your workers are paid on time? (SHOW EXAMPLE WHEN ASKING THIS QUESTION) ☐ Yes ☐ No ☐ Yes, with help
6. Do you think you can keep the paperwork in a safe place in case the program needs to review it? ☐ Yes ☐ No ☐ Yes, with help
7. Can you tell your workers what you like and do not like about their work? ☐ Yes ☐ No ☐ Yes, with help
8. Can you fire your worker if necessary? ☐ Yes ☐ No ☐ Yes, with help
9. Can you manage your worker’s schedule to make sure they do not work more hours than you can pay them for? (SHOW EXAMPLE OF SCHEDULE WHEN ASKING THIS QUESTION) ☐ Yes ☐ No ☐ Yes, with help
10. Do you have any questions or concerns about directing your services? ☐ Yes ☐ No
    If you do have questions or concerns, what are they?

ADMH DDD Provider Money Management Guidance

	Individual	Provider	Outcomes
Rights & Privileges	• Must be given the option to decide how to spend, save, keep, give away, invest, or direct their money • Must be provided the option to possess a checking or savings account, or other means to control his/her funds (i.e., debit card, refillable debit card, or personal checks, etc.) • Must be offered informed choices to control monetary resources • Must be offered training in utilizing their own money	• Offer to assist individuals served with money management (individualized budget) of their funds • Ensure timely/prompt access of monetary funds as requested by individuals served • Ensure that individual needs are met and sustained • Provide training to individuals served on how to access and manage their money • Any modifications of conditions of HCBS must be supported by a specific assessed need and justified in the PCP	• Optimize individuals served independence in accessing and using money • Ensure individual preferences are supported and rights are protected • Ensure services and supports are self-directed
Access to Money	• Must be able to access funds at will • Provided the option to manage his/her own personal funds	• Maintain a separate account for individuals served • Provide individuals served monthly reports of expenditures • Offer individuals served the option to create an Able Savings Plan to store monies with a maximum allowable balance of **$100,000** • Ensure that available funds on-site (petty cash) do not exceed **$300** per individual • Provide an assessment tool to help manage funds for individuals served who choose not to manage their own funds	• Promote financial independence for individuals served • Ensure individuals served spend their money in a manner reflecting their personal choices/preferences
Financial Accountability	• Must be provided monthly financial statements to see how individual funds are utilized • Must be given the option to participate in the monthly, individualized budget process • Must be assured by the provider agency that their monies are kept safe and protected from fraud or misuse	• Implement a check and balance system to include monthly review of individualized financial statements or expenditure reports with designated staff • Offer monthly meetings with individuals served to discuss individual budgets and expenditures (i.e., picture board or graphics) • Implement an internal, electronic financial monitoring and tracking system for individual budget expenditures (i.e., Quicken or a Microsoft Excel spreadsheet) • Hire or consult with a financial expert or certified accountant	• Minimize risks of budgetary inconsistencies, fraud, or improper documentation/use of federal/state funds • Allow for financial maintenance/sustainability in the event of auditing or staff changes • Engage individuals served in seeing how their monies are disbursed according to their preferences
Auditing	• Must be made aware that individuals' funds will be subject to auditing and reporting	• Maintain a filing system of receipts (can be scanned copies electronically for additional safekeeping) • Required compliance audits are performed according to provider entity type (See Additional Resources) • Maintain fiscal records for a minimum of **3 year**	• Ensure fiscal integrity • Ensure all financial transactions and recordkeeping have been properly documented in accordance with state and federal mandates • Validate individual services/supports costs
Additional Resources	• Microsoft Word - AUDIT GUIDE 2016.rtf (alabama.gov) • 2.-Internal-Audit-Managers-Letter.pdf (alabama.gov) • HCBS Rule Residential Setting-Specific Transition to Compliance Plan.xlsx (alabama.gov) • HCBS Rule Non-Residential Setting-Specific Transition to Compliance Plan.xlsx (alabama.gov)		

Alabama Department of Mental Health
Division of Developmental Disabilities
Community Waiver Program (CWP)

Client Satisfaction Form For Minor Home Modifications

Participant____________________

Address___________________________
____
Phone_____________________________

As a participant in the CWP indicated above, my signature indicates that I received the following service and am satisfied with it: (support coordinator should write in the service(s) received

____

____

_________________________________ _______________________
Participant/Parent/Guardian Date

_________________________________ _______________________
Support Coordinator Date

Division of Developmental Disabilities
RSA Union Building
100 North Union Street, Suite 486
P.O. Box 301410
Montgomery, AL 36130-1410