

Section VI

WAIVER SERVICES

Introduction

The NHTD Waiver Services are designed to address the unique needs of the participants. All other services including informal supports, non-Medicaid services, federally funded services and Medicaid State Plan services are explored before utilizing waiver services. The provision of waiver services must be cost effective and necessary to avoid institutionalization.

This section describes each of the waiver services, provider qualifications and reimbursement for the service.

Service Coordination

Definition

Service Coordination is an individually designed intervention which provides primary assistance to the waiver applicant/participant in gaining access to needed waiver and Medicaid State Plan services, as well as other local, state and federally funded educational, vocational, social, medical and any other services. These interventions are expected to result in assuring the waiver participant's health and welfare and increasing independence, integration and productivity. The Service Coordinator (SC) will assist the applicants/participants in obtaining and coordinating the services that are necessary to return to or remain in the community.

Roles and Responsibilities

The applicant/participant is the primary decision-maker in the development of goals, and selection of supports and individual service providers. The SC is responsible for assuring that the SP is implemented appropriately and supports the participant to become an effective self-advocate and problem solver. Together they work to develop and implement the SP, which reflects the participant's goals.

The SC assists the applicant/participant in the development of the individualized SP and will include those individuals chosen by the applicant/participant to also participate in the process. Following the approval of the SP, the SC will assist the waiver participant in implementing the plan, as well as reviewing its effectiveness. Throughout his/her involvement with the waiver participant, the SC will support and encourage the waiver participant to increase his/her ability to problem-solve, be in control of life situations, and be independent. The SC will also assist the applicant/participant to complete the Plan of Protective Oversight (PPO) (refer to Appendix C – form C. 4).

Questions that a SC should explore with the participant include:

- What are the participant's goals?
- What can be done to help the participant fulfill his/her goals?
- How can the participant be assisted to become a member of the community?
- What can be done to assist the participant to be more independent?

The SC must also be an effective advocate for the participant, so the participant obtains needed benefits for which he/she is eligible and receives appropriate and adequate services.

The SC is responsible for assuring that all waiver service providers receive a copy of the most up-to-date SP.

Types of Service Coordination

Service Coordination has two basic components:

- 1) Initial; and
- 2) Intensive

1. Initial Service Coordination

This component has three types of Service Coordination available to the waiver applicant:

- Initial Service Coordination Diversion - This type of Service Coordination is provided to individuals who are new to the waiver and presently living in the community. This will occur only once per waiver enrollment.
- Initial Service Coordination Transition - This type of Service Coordination is provided to individuals who are new to the waiver and presently living in a nursing home for less than six months. This will occur only once per waiver enrollment.
- Initial Service Coordination Transition - This type of Service Coordination is provided to individuals who are new to the waiver and presently living in a nursing home for six months or more. This will occur only once per waiver enrollment.

Initial Service Coordination encompasses those activities involved in developing the individual's Application Packet. After the individual selects a SC, it is the SC's responsibility to gain a full understanding of who this person is now, his/her life experiences, and his/her goals for the future. It is essential to interview those individuals who are of primary importance to the applicant. Information from community services and medical facilities/practitioners providing services to the individual including information from a discharging facility should be obtained.

In assisting the individual to develop the ISP (refer to Appendix C – form C.1), the SC should look to sources of support – informal caregivers (family, friends, neighbors, etc.), non-Medicaid federal and state funded services, such as VESID, Medicare and other third party payers and Medicaid funded services (physician, personal care, nursing, etc). The waiver services are designed to complement other available supports and services available to Medicaid recipients. Waiver services can be substituted for Medicaid State Plan services when there are greater efficiencies, such as the use of Congregate and Home Delivered Meals in lieu of a personal care assistant preparing a meal.

Another important task of the SC is to assist the participant in locating a place to live in the community. The NHTD waiver supports the individual's right to choose where to live and to have access to integrated and accessible housing that falls within the individual's economic means.

There are no certified residences specifically/directly associated with the waiver;

participants may live with up to three (3) other non-related individuals, unless they are in a living situation which is certified or licensed by the State (e.g. an Office of Mental Hygiene supported Residential Program for Adults or an Adult Care Facility). The SC is to assist the waiver participant to secure housing.

2. Intensive Service Coordination

This component has one type of Service Coordination available to the waiver applicant:

- Intensive Service Coordination - This type of Service Coordination is provided to participants on an ongoing basis.

Intensive Service Coordination is ongoing and begins after the individual is approved to become a waiver participant and has been issued a Notice of Decision (NOD). The SC is responsible for the timely and effective implementation of the approved SP. The SC is responsible for assuring that there is adequate coordination, effective communication, and maximum cooperation between all sources of support and services for the participant.

During the first six (6) months of the ISP, the SC will conduct face-to-face meetings with the waiver participant at least monthly to provide closer monitoring of the participant's health and welfare needs as he/she adjusts to the waiver program. It is expected that at least one of these visits will be conducted in the participant's home. In addition, these meetings can provide monitoring opportunities for the SC to assure that all approved services are being provided. Thereafter, the SC will conduct face-to-face meetings with the waiver participant as determined through discussion with the participant and as authorized in the SP. These meetings must occur, at a minimum, once every six (6) months. The SC will assure that the participant is aware that he/she may contact the SC if issues/problems occur.

The ultimate responsibility for assuring that the SP is appropriately implemented rests with the SC.

A SC must be knowledgeable about all waiver services, Medicaid State Plan Services, and available non-Medicaid services. Informal supports are often a crucial factor if the participant is to live a satisfying life and remain in the community. The SC's ability to make use of these informal supports is essential, and offers the SC and other providers the greatest opportunity for creativity. In addition, the SC must be knowledgeable of the processes necessary to obtain needed referrals/orders, assessments and approvals for non-waiver service.

The SC will also be responsible for:

1. Formally reviewing, updating and submitting all SPs to the Regional Resource Development Specialist (RRDS) for review in a timely manner (refer to Section V – The Service Plan);
2. Assuring that Team Meetings are held at least six (6) weeks prior to the

- end of the most recently approved SP period and/or on an as needed basis;
3. Providing all waiver providers, the participant and others, as appropriate, with written summaries of the Team Meetings (refer to page 8 for more information on Team Meetings);
 4. Maintaining records for at least six (6) years after termination of waiver services;
 5. Maintaining a tracking system for level of care evaluations and assuring that the PRI and SCREEN (refer to Appendix F) is completed:
 - a. at least every twelve months; or
 - b. when the participant experiences a significant improvement in his/her ability to function independently in the community;
 6. Assuring that a signed Release of Information is obtained to disclose the ISP, Addendum or RSP and other documents generated in the provision of service to the participant. This information will be shared as needed with waiver service providers and others as directed by the participant;
 7. Maintaining knowledge of all approved waiver service providers in their region;
 8. Conducting face-to-face meetings with the participant and at a minimum:
 - 1) Review the SP with the participant to determine if the services are meeting the participant's needs;
 - 2) Discuss the provision of services with the participant to determine the participant's level of satisfaction with the services he or she is receiving; and
 - 3) Review the Service Coordination Detailed Plan with the participant to discuss the participant's progress towards meeting his or her goals.
 9. Conducting in-home visits with the waiver participant at least once every six (6) months, prior to the development of the Service Plan;
 10. Reviewing all NODs with the participant and assuring that the participant understands his/her rights to an Informal Conference and/or Fair Hearing;
 11. Ensuring that the participant understands and signs the Waiver Participant's Rights and Responsibilities (refer to Appendix C – form C. 5) annually;
 12. Assuring that the participant is provided with information regarding abuse/neglect prevention and how to report any incidents of abuse/neglect if it does occur;
 13. Working with the participant to develop and maintain a Detailed Plan

for Service Coordination which includes coordination of team in the provision of services, and overall activities and goals of the SC;

14. Documenting all visits, contacts, meetings, etc. involving the participant in the SC's record;
15. Working with the participant on a safe discharge/discontinuation plan if he/she is leaving the NHTD waiver. In many cases, this will include collaboration with Local Department of Social Services (LDSS) to establish alternative services; and
16. Administering the Quality of Life (QoL) Survey for applicants who have resided in a nursing home for at least six (6) months prior to transitioning into the community. The QoL Survey must be administered within two (2) weeks of the anticipated discharge of the individual from the nursing home.

Although the SC is an employee of a provider agency, the SC must always act as the participant's advocate and provide unbiased assistance to the participant with the selection of providers.

Ratio of Waiver Participants to SC

- Full time SC for NHTD waiver participants may not exceed a caseload of twenty (20) waiver participants.
- SCs providing services to NHTD waiver participants on less than a full time basis must limit their caseload proportionately. For example, a SC working 50 percent may not exceed a caseload of ten (10) waiver participants.

Provider Qualifications

Not-for-profit or for profit health and human services agencies may provide Service Coordination. The agency must be approved by DOH as a NHTD waiver provider.

I. Qualifications for a SC are:

- (A) (1) Master of Social Work;
- (2) Master in Psychology;
- (3) Registered Physical Therapist – Licensed by the NYS Education Department;
- (4) Registered Professional Nurse –Licensed by the NYS Education Department;
- (5) Certified Special Education Teacher – Certified by the NYS Education Department;
- (6) Certified Rehabilitation Counselor – Certified by the Commission of Rehabilitation Counselor Certification;
- (7) Licensed Speech-Language Pathologist - Licensed by

- the NYS Education Department; or
- (8) Registered Occupational Therapist – Licensed by the NYS Education Department.

The individual shall have, at a minimum, one (1) year of experience providing service coordination and information, linkages and referrals regarding community-based services for individuals with disabilities and/or seniors; OR

- (B) Be an individual with a Bachelor's degree and two (2) years experience providing service coordination for individuals with disabilities and/or seniors and knowledge about community resources; or
- (C) Be an individual with a High School Diploma with three (3) years' experience providing service coordination for individuals with disabilities and/or seniors and knowledge about community resources; or
- (D) Be an individual who has successfully served as a Regional Resource Development Specialist for one (1) year.

II. The following individuals may be hired and must be supervised by individuals identified in Section I (A) above to perform Service Coordination Services:

- (A) Individuals with educational experience listed in I (A) but who do not meet the experience qualification;
- (B) Individuals with a Bachelor's degree with one (1) year of experience providing service coordination for individuals with disabilities and/or seniors and knowledge about community resources; and
- (C) Individuals with a High School Diploma and two (2) years of experience providing service coordination to individuals with disabilities and/or seniors and knowledge about community resources.

The supervisor of the above listed staff is expected to:

1. Meet any potential participants prior to the completion of the ISP developed by a SC under their supervision;
2. Have supervisory meetings with staff on at least a bi-weekly basis and maintain notes on these meetings;
3. Document progress of staff and conduct regular performance evaluations; and
4. Review and sign-off on all Service Plans.

A supervisor may maintain an active caseload of waiver participants in accordance with ratio guidelines.

The Service Coordination agency must have available a communication system for 24 hours/seven days per week coverage to assure any issues regarding a participant's services can be addressed.

Team Meetings

The SC must be a strong and effective team leader. After the participant has selected all service providers, the SC organizes the team to provide individualized services for the participant. The SC needs to coordinate communication among all team members, including the participant. This becomes especially important when cognitive deficits affect the participant's memory. Maintaining good communication contributes towards effective coordination of services to support the participant in the community.

Team Meetings are scheduled based on the service needs of the participant but must be held at a minimum of every six (6) months when the RSP is being developed. A new waiver participant may benefit from monthly meetings initially with the entire team.

The SC coordinates and facilitates the Team Meeting. The participant, his/her legal guardian if applicable, and all waiver service providers for the individual must attend each Team Meeting. (Exceptions to Team Meeting attendance may be made at the discretion of the SC for providers of Assistive Technology (AT), Community Transition Services (CTS), Congregate and Home Delivered Meals, Environmental Modifications(E-mods), Moving Assistance, Home Visits by Medical Personnel, and Respite Services. Failure to attend may jeopardize the ability of the waiver provider to continue to provide waiver services. Providers of essential non-waiver services and anyone identified in the Plan for Protective Oversight should also be invited to Team Meetings. Other potential members of the Team Meeting include advocates, family members, local department of social services staff, etc. If the waiver participant is receiving the same service from different waiver providers, both providers should attend the Team Meeting.

The SC is responsible for facilitating effective communication between the participant and all service providers. To assure services are provided in the most integrated and efficient manner, it is necessary for providers to attend regularly scheduled Team Meetings to discuss progress toward the participant's goals, identify any impediments to achieving projected milestones and address any issues affecting the participant. Regularly scheduled Team Meetings with the participant and service providers are an essential part of assuring the participant's health and welfare.

Team meetings are scheduled by the SC six (6) weeks prior to the end of the most recently approved SP period and/or on an as needed basis. Prior to or at the time of the Team Meeting, all waiver providers required to submit an updated ISR must do so to assure the development of the RSP. Timely submission of

Individualized Service Reports (ISR) (refer to Appendix C – form C.16) is imperative to maintain continuity of services to the participant. In addition, the SC may need to obtain information from non-waiver providers or other parties prior to the meeting. The RRDS may consult with the SC to determine if Team Meetings are being used appropriately.

On limited occasions, service providers may indicate the need to meet without the participant (e.g. the participant's behavior or other factors jeopardize the participant's ability to remain in the community). The SC is responsible for informing the RRDS of the team's interest in holding a meeting without the participant. Following the meeting, the SC and other members of the team must meet with the participant to explain the results of the meeting. This exception does not apply when the team is meeting to develop a RSP.

Team Meetings must be documented in the SP by the SC. Participation in Team Meetings must be documented in the notes of each active waiver service provider, including date, time and location, and projected activities (refer to Section VII – Record Keeping).

In addition, the SC completes the Team Meeting Summary form (refer to Appendix C – form C.17 which includes:

- Date, time and location of Team meeting;
- Participant's (or designated representative's) input and comments;
- Issues Addressed;
- Recommendations for changes in the Service Plan (e.g. addition, decrease, increase or discontinuation of service(s));
- Who was in attendance; and
- Submission and acceptance of all required ISRs or documentation of reasons for any delay or resubmission.

The SC distributes a copy of the completed Team Meeting Summary to all active waiver service providers for review and acceptance. A final copy is then provided to the participant. Any concerns regarding the content of the Team Meeting Summary should be directed to the SC. All active waiver service providers must maintain a copy of the Team Meeting Summary in the participant's record.

Team Meetings may not be used by the SC for required face-to-face visits.

Team Meetings are organized and facilitated by the SC as part of his/her responsibility to oversee services. Reimbursement for this activity is included in the monthly rate for Service Coordination. All other waiver service providers participating in a Team Meeting will be reimbursed at the usual rate for their service (e.g. Community Integration Counseling (CIC) will be able to bill as a face-to-face session with the participant).

Reimbursement for Service Coordination

Service Coordination must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

There are two (2) types of reimbursement for Service Coordination:

1. Initial Service Coordination is reimbursed on a one-time only basis for each participant after the individual is an approved participant in the waiver. Reimbursement is for the work, time and travel expended in developing the Application Packet, including the Initial Service Plan.

There are three (3) rates for Initial Service Coordination. These are based on whether the person is in the community and how long an individual has been in a nursing home. These are:

- Diversion
- Transition - six (6) months or less in a nursing home
- Transition - greater than six (6) months in a nursing home

2. Intensive Service Coordination is reimbursed in monthly units. As with all waiver services, Service Coordination must be included in the SP and can only be billed after the service is delivered. For reimbursement purposes, at a minimum, the SC must have at least one face-to-face meeting with the participant in the month for which bills are being submitted.

Assistive Technology (AT)

Definition

The purpose of this service is to supplement the Medicaid State Plan Service for Durable Medical Equipment and supplies, which provides a broad range of special medical equipment and supplies. The Medicaid State Plan and all other resources must be explored and utilized before considering AT. Durable Medical Equipment covered by the Medicaid State Plan can be found at www.emedny.org under 'Provider Manuals'.

An Assistive Technological device may include an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or to improve the functional capabilities of the waiver participants. AT service is a service that directly assists a waiver participant in the selection, acquisition, or use of an assistive technology device. This service will only be approved when the requested equipment and supplies improve or maintain the waiver participant's level of independence, ability to access needed supports and services in the community or, maintain or improve the waiver participant's safety.

Documentation must describe how the waiver participant's expected use, purpose and intended place of use have been matched to features of the products requested in order to achieve the desired outcome in an efficient and cost effective manner.

AT may be obtained at the time the individual becomes enrolled as a participant, no more than thirty (30) days prior to the initial NOD, or during the development of any SP. Requests for AT must be less than \$15,000 per 12-month period. For example: If a participant needs more than one type of AT device during the twelve (12) month period, the combined cost for this period may not exceed \$15,000. A contract for AT resulting in an amount of \$15,000 or more per 12-month period must be approved by DOH.

Provider Qualifications

AT Services are purchased through vendors who sell the needed medical, communication and adaptive equipment or supplies.

Providers of Assistive Technology must be:

1. Approved by DOH under Section 504 of Title 18 NYCRR;
2. Providers of AT services to the HCBS waiver administered by OMRDD;
3. A licensed pharmacy; or
4. For Personal Emergency Response Systems (PERS), an approved provider of PERS which have existing contracts with the LDSS.

Providers of AT must ensure that all devices and supplies meet standards established by Underwriters Laboratory and/or comply with FCC Regulations, if appropriate.

The provider of this service is responsible for training the waiver participant, natural (informal) supports and paid staff who will be assisting the waiver participant in using the equipment or supplies.

Approval Process for AT Services

Step 1 The participant, his/her legal guardian, the SC, and anyone selected by the participant determine if any AT is needed during the development of any SP.

This must be done in conjunction with an assessment by either an Independent Living Skills Trainer (ILST) or other professional who is knowledgeable about the full range of devices and/or technology to assist individuals with disabilities or seniors.

Step 2 The participant and SC explore and utilize all possible funding sources including: private insurance; community resources; non-Medicaid federal and state funding (e.g. Medicare); and/or other federal/State programs. These funding sources must be accessed with documentation of denial prior to requesting AT Services.

Step 3 If NHTD funding is required for the device(s), the SC initiates the process for submission of the AT request to the RRDS using the Assistive Technology Description and Cost Projection form (refer to Appendix C – form C.9). Information that must be submitted includes but is not limited to:

- Justification for the AT, indicating how the specific equipment will meet the needs and goals of the participant in an efficient and cost effective manner;
- Copies of all assessments made to determine the necessary AT, including an assessment of the participant's unique functional needs and the intended purpose and expected use of the requested AT. The assessment must include a description of the ability of the equipment to meet the individual's needs in a cost effective manner;
- When the AT will require modifications to the participant's residence, information must also include the name of the home owner or landlord and their permission for the modifications/adaptations; and
- Date the AT is needed.

- Step 4** The SC obtains bids from approved AT providers. The SC must select an approved provider based on reasonable pricing and obtain a written bid stating all terms and conditions of sale.
- For an item of AT costing up to \$1,000 per 12 month period, only one bid is required.
 - For an item of AT costing \$1,000 or more per 12 month period, three bids are required.
- The lowest bid for comparable equipment will be selected.
- Step 5** The SC completes the Assistive Technology Description and Cost Projection form and attaches all bids obtained. The SC reviews the form with the applicant/participant and both the SC and applicant/participant signs.
- Step 6** The SC submits the complete Assistive Technology Description and Cost Projection form along with the Initial or Revised Service Plan, or Addendum to the RRDS.
- Step 7** The RRDS reviews the Assistive Technology Description and Cost Projection form and may request more information. Approval is contingent upon available funding. The RRDS notifies the SC of the approval.
- Step 8** The SC notifies the AT provider.
- Step 9** The AT provider completes and signs the Waiver Services Final Cost form (refer to Appendix C – form C.11) with the participant;
- Step 10** The AT provider sends the Waiver Services Final Cost form to the SC who signs off and submits the form to the RRDS;
- Step 11** The RRDS reviews the Waiver Services Final Cost form and completes the RRDS Approval of Final Cost form. The RRDS provides a copy of the RRDS Approval of Final Cost form to the AT provider and SC;
- Step 12** The AT provider seeks reimbursement after receiving a copy of the NOD from the SC.

Repairs

Repairs to AT which are cost effective may be allowed. Items that have worn out through normal everyday use (keyboards, switches, etc.) may be replaced using the same procedures that were followed to initially acquire the item. There are situations where replacement or repair will be contingent on establishing a plan that would minimize repeated loss or damage. The SC is responsible for working with the team to develop and implement a plan to prevent repeated loss or damage.

Reimbursement

AT must be provided by a DOH approved provider and included in the SP to be reimbursed.

AT is reimbursed based on the lowest of two costs: wholesale plus 50% or the retail cost. Repairs and replacement of parts are reimbursed at the retail cost. AT obtained no more than thirty (30) days prior to the initial NOD are reimbursed after the NOD is issued.

Community Integration Counseling (CIC)

Definition

Community Integration Counseling (CIC) is an individually designed service intended to assist waiver participants who are experiencing significant problems managing the emotional responses inherent in adjusting to a significant physical or cognitive disability while living in the community. It is a counseling service provided to the waiver participant who is coping with altered abilities and skills, a revision of long term expectations, or changes in roles in relation to significant others. This service is primarily provided in the provider's office or the waiver participant's home. It is available to waiver participants and/or anyone involved in an ongoing significant relationship with the waiver participant when the issues to be discussed relates directly to the waiver participant. It is expected that CIC will be conducted on a short-term basis. The need for CIC could occur at the time of transition from a nursing home or at various times during the participant's involvement in the NHTD waiver.

While CIC Services are primarily provided in a one-to-one session to either the waiver participant or a person involved in an ongoing relationship with the participant, there are times when it is appropriate to provide this service to the waiver participant or other in a family counseling or group counseling setting.

Regarding client confidentiality, the sharing of information obtained during a CIC session can only be disclosed in accordance with federal standards and accepted professional standards regarding client confidentiality.

CIC must not be used to assist the participant to become physically integrated into his/her environment. This function is the responsibility of other service providers, such as SCs, ILST and Home and Community Support Services (HCSS).

Provider Qualifications

CIC may be provided by any not-for-profit or for profit health and human services agency.

A CIC must be a:

- (A) 1. Licensed Psychiatrist - Licensed by the NYS Education Department;
2. Licensed Psychologist - Licensed by the NYS Education Department;
3. Master of Social Work;
4. Master of Psychology;
5. Mental Health Practitioner – Licensed by the NYS Education Department;
6. Certified Rehabilitation Counselor – Certified by the Commission on Rehabilitation Counselor Certification; or

7. Certified Special Education Teacher- Certified by the NYS Education Department.

Each of these individuals must have, at a minimum, two years of experience providing adjustment related counseling to individuals and/or seniors with physical and/or cognitive disabilities and their families. A significant portion of the provider's time which represents this experience must have been spent providing counseling to individuals with disabilities and/or seniors and their families in order to be considered qualifying experience.

Individuals listed in (A) may supervise the following individuals to perform CIC services:

- (B) 1. Licensed Psychiatrist - Licensed by the NYS Education Department;
2. Licensed Psychologist Licensed by the NYS Education Department;
3. Master of Social Work;
4. Master of Psychology;
5. Mental Health Practitioner – Licensed by the NYS Education Department;
6. Certified Rehabilitation Counselor - Certified by the Commission on Rehabilitation Counselor Certification; or
7. Certified Special Education Teacher - Certified by the NYS Education Department.

Individuals in section (B) may have less than two years of experience providing adjustment related counseling to individuals and/or seniors with physical, cognitive, developmental or psychiatric disabilities.

Supervisors are responsible for providing ongoing supervision and training to staff. Supervision must occur no less than once a month when reviewing the caseload and must be more frequent when there is a new participant, a new provider or there has been a significant change in the participant's emotional, psychiatric or life situation.

Reimbursement

CIC services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

CIC is reimbursed in one hour units. Participation in Team Meetings is reimbursed at the hourly rate for this service.

If CIC is provided in a group setting, the hourly rate is divided evenly among the participants. For instance, if the participant is one of four people in the group, only one quarter of an hour is billable to that participant. Providers must accumulate billable units until a whole hour is reached before billing for the service.

Community Transitional Services (CTS)

Definition

Community Transitional Services (CTS) are defined as individually designed services intended to assist a waiver participant to transition from a nursing home to living in the community. CTS is a one time service per waiver enrollment. If the waiver participant has been discontinued from the program and now is a resident of the nursing home, they can access this service again, if needed. This service is only provided when transitioning from a nursing home. These funds are not available to move from the participant's home in the community to another location in the community. The funding limits for this service are separate and apart from the limits applied to Moving Assistance, and the two services will not be used at the same time in any approved Service Plan.

CTS provide funding for the reasonable costs of one-time set-up expenses for individuals transitioning from a nursing home to their own home or apartment in the community. Reasonable costs are defined as necessary expenses for an individual to establish his/her living space.

These services must be included in the ISP and may not exceed \$5,000 per waiver enrollment, including the 10% administrative fee payable to the CTS provider. Approved costs will be covered by CTS up to thirty (30) days prior to the individual's discharge into the community.

This service includes:

- The cost of moving essential furniture and other belongings;
- Security Deposits, including broker's fees to obtain a lease on an apartment or home;
- Purchasing essential furnishings;
- Set up fees or deposits for utility or service access (e.g. telephone, electricity, heating);
- Health and safety assurances, such as pest removal, allergen control or one-time cleaning prior to occupancy.

This service will not be used to purchase diversional or recreational items, such as television/ VCRs/ DVDs/ or music systems.

Provider Qualifications

All CTS providers must be approved providers of Service Coordination in the NHTD waiver. When the participant chooses the provider of CTS it does not have to be the same agency providing Service Coordination to the participant. Someone other than the participant's SC must be the individual responsible for arranging CTS. The provider of this service must designate an individual who has sufficient knowledge and skills to work with subcontractors and to assist the participant in utilizing this service.

Approval Process for CTS

- Step 1** The applicant, SC, and anyone selected by the applicant, determines if any CTS is required prior to discharge from the nursing home into the community.
- Step 2** If appropriate, a comprehensive list of the items needed or anticipated expenses is developed by the applicant and SC.
- Step 3** The applicant and SC explore all possible resources including informal supports and community resources for these items.
- Step 4** After all other resources are explored and utilized, the SC compiles a detailed list of items and anticipated expenses using the Community Transitional Services Description and Cost Projection form (refer to Appendix C – form C.9);
- Step 5** The SC and applicant select an approved CTS provider and include the contact information on the Community Transitional Services Description and Cost Projection form.
- Step 6** After completing the Community Transitional Services Description and Cost Projection Form, the applicant and SC sign the form.
- Step 7** The SC sends the Community Transitional Services Description and Cost Projection Form to the CTS provider for their signature and Medicaid provider number.
- NOTE:** For moving costs and for services for health and safety assurances (e.g. cleaning) – if the cost of either one of these services is greater than \$1,000, three (3) bids must be obtained and submitted by the CTS provider, along with the CTS Description and Cost Projection form.
- Step 8** The CTS provider returns the completed Community Transitional Services Description and Cost Projection form to the applicant's SC.
- Step 9** The SC submits the complete Community Transitional Services Description and Cost Projection form with the ISP to the RRDS.
- Step 10** The RRDS reviews and approves the costs detailed for CTS.
- Step 11** The RRDS notifies the SC of approval for CTS.
- Step 12** The SC notifies the CTS provider that the applicant has been approved for CTS.
- Step 13** The CTS provider makes the approved payment directly to the broker, utility company and/or the landlord for a security deposit. The CTS provider purchases the approved essential furnishings

with prior approval by the RRDS. All receipts and any remaining balance must be maintained by the CTS provider.

- Step 14** The CTS provider completes the Waiver Services Final Cost form, which certifies that the CTS was provided in accordance with the ISP. The CTS provider must maintain original receipts. A copy of the original receipts is attached to an itemized list of items purchased to the Waiver Services Final Cost form and submitted to the SC.
- Step 15** The SC signs the complete Waiver Services Final Cost form and submits it to the RRDS for approval.
- Step 16** The RRDS completes the RRDS Approval of Final Cost form and provides a copy to the CTS provider and SC.
- Step 17** The CTS provider seeks reimbursement after receiving a copy of the NOD – Authorization from the SC.

Reimbursement

CTS must be provided by a DOH approved provider and included in the Initial SP to be reimbursed. Prior to making the purchases, if the cost is greater than 10% more than the estimate then another Community Transitional Services Description and Cost Projection form has to be submitted to justify the request. Reimbursement will not be provided if the actual cost of the CTS exceeds ten (10) percent of the projected cost and the CTS provider did not obtain prior approval.

This Service is reimbursed on a cost basis. Total one-time reimbursement for CTS must not exceed \$5,000 per waiver enrollment, which may include a 10% administrative fee payable to the CTS provider.

Congregate and Home Delivered Meals

Definition

Congregate and Home Delivered Meals is an individually designed service which provides meals to waiver participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. These meals will assist the waiver participant to maintain a nutritious diet. These meals do not constitute a full nutritional regimen. Therefore the maximum number of meals the participant may receive per day is two (2). It is not to be used to replace the regular form of “board” associated with routine living in an Adult Care Facility. Individuals eligible for non-waiver nutritional services would access those services first.

Provider Qualifications

Providers of Congregate and Home Delivered Meals are either contracted through Area Agencies on Aging (AAA) or those entities contracted through the Area Agency on Aging for Congregate and Home Delivered Meals.

Reimbursement

Congregate and Home Delivered Meals must be documented in the SP and provided by agencies approved by DOH.

This service is reimbursed on a per meal basis.

Attendance at Team Meetings for Congregate and Home Delivered Meal providers will be determined by the SC.

Environmental Modifications Services (E-mods)

Definition

Environmental Modifications (E-mods) are internal and external physical adaptations to the home, which are necessary to ensure the health, welfare and safety of the waiver participant. These modifications enable the waiver participant to function with greater independence and prevent institutionalization.

E-mods must be provided where the waiver participant lives. If a waiver participant is moving to a new location which requires modifications, the modifications may be completed prior to the waiver participant's move. If an eligible individual is residing in an institution at the time of the application, the modifications may be completed no more than thirty (30) days prior to the waiver participant moving into the modified dwelling. All modifications must meet State and local building codes.

Modifications may also be made to a vehicle if it is the primary means of transportation for the waiver participant (referred to as vehicle modifications). An E-mod may alter the basic configuration of the waiver participant's home only if this alteration is necessary to successfully complete the modification. All environmental and vehicle modifications must be included in the SP and provided by agencies approved by DOH.

E-mods, including vehicle modifications, have a limit of up to \$15,000 per twelve (12) month period. For example: if a participant needs more than one type of E-mod during the twelve (12) month period, the combined cost for this period may not exceed \$15,000. E-mods in the amount of \$15,000 or more per twelve (12) month period must be approved by DOH.

E-mods do not include improvements to the home (carpeting, roof repair, central air conditioning), which are not medically necessary or are not necessary to the waiver participant's independence in the home or community.

Allowable E-mods

E-mods in the home include the purchase and/or installation of:

- Ramps
- Lifts: hydraulic, manual or electric, for porch, bathroom or stairs (Lifts may also be rented if it is determined that this is more cost-effective.)
- Widened doorways and hallways
- Hand rails and grab bars
- Automatic or manual door openers and doorbells

Bathroom and kitchen modifications, additions or adjustments to allow accessibility or improved functioning, include:

- Roll-in showers
- Sinks and tubs

- Water faucet controls
- Plumbing adaptations to allow for cutouts, toilet/sink adaptations
- Turnaround space changes/adaptations
- Worktables/work surface adaptations
- Cabinet and shelving adaptations

Other home adaptations include:

- Medically necessary heating/cooling adaptations required as part of a medical treatment plan. (Any such adaptations utilized solely to improve a person's living environment are not reimbursable under the waiver.)
- Electrical wiring to accommodate other adaptations or equipment installation.
- Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that have been determined medically necessary.
- Other appropriate E-mods, adaptations or repairs necessary to make the living arrangements accessible or accommodating for the participant's independence and daily functioning and provide for emergency fire evacuation and necessary to assure the waiver participant's health, welfare or safety.

Provider Qualifications

Any not-for-profit or for profit health and human services agency may provide E-mods or may subcontract with a qualified person or entity to provide E-mods. Agencies approved to provide E-mods by the Office of Mental Retardation and Developmental Disabilities (OMRDD) may be approved by DOH to provide this service for the NHTD waiver.

The E-mod provider must ensure that individuals working on the E-mods are appropriately qualified and/or licensed to comply with any State and local rules. All materials and products used must also meet any State or local construction requirements.

Providers must adhere to safety issues addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act as well as all local building codes.

Approval Process for E-mods for a home

- STEP 1** The participant, SC, and anyone selected by the participant determines if any E-mods are required during the development of any SP;
- STEP 2** A comprehensive assessment must be completed to determine the specifications of the E-mod;

STEP 3 The participant, the SC and anyone selected by the participant must explore all other available resources to pay for E-mods (i.e. informal supports, community resources and State/Federal agencies);

STEP 4 When all other resources have been explored and/or utilized, the SC begins the bid procurement and selection process;

There are two options for obtaining bids:

1. The SC and participant select a waiver approved E-mod provider to be responsible for planning, oversight and supervision of the project. The provider is then responsible for obtaining three bids from skilled professionals and selecting the contractor; OR
2. The SC and participant obtain three bids from providers who are responsible for planning, oversight and supervision of the project and have the personnel and expertise to complete the E-mod.
 - For E-mods of less than \$1,000, only one bid is necessary.
 - For E-mods of \$1,000 or more, three bids are necessary.

Any combination of these two options can be used to obtain three bids. The lower bid must be selected, unless there is an indication that the contractor did not understand the full scope of the work or is unable to deliver the needed service. Every reasonable effort must be made to acquire the required three bids.

When the SC determines that the continued delay due to lack of the required number of bids is jeopardizing the participant's health and welfare or is preventing an applicant from leaving an institution, the SC must contact the RRDS. The RRDS will consult with DOH and will notify the SC if they can proceed without the required three bids.

STEP 5 The SC completes and submits the E-mod proposal using the E-mod Description and Cost Projection form (refer to Appendix C – form C.10) to the RRDS for review and approval along with the SP. Information that must be submitted includes but is not limited to:

1. Justification for the E-mod.
2. All comprehensive assessments completed to determine the specifications of the E-mod.
3. Information regarding the residence where the E-mod is proposed, including the name of the home owner or landlord.

The owner's approval for the renovations, including any lease or rental contract, must be included (DOH is not responsible for the cost of restoring a site to its original configuration or condition).

4. If the participant or family is having other renovations or repairs done to the house along with the E-mods, the scope of work should clearly delineate the waiver covered E-mods from modifications being funded by the family;

STEP 6 The RRDS reviews the Environmental Modification Description and Cost Projection form and may request more information. Approval is contingent upon available funding. The RRDS completes and signs the E-mod Description and Cost Projection form. The RRDS sends a copy of the form to the SC with the final determination.

STEP 7 The SC notifies the E-mod provider of the approval and obtains a signed contract from the E-mod provider. The E-mod provider is responsible for coordination of the E-mod, including obtaining necessary permits, supervising the construction, beginning and ending dates, and satisfactory completion of the project.

Signed contracts must be forwarded to the RRDS and must result in a total of less than \$15,000 per twelve (12) month period. Any changes in cost must be prior approved by the RRDS through an Addendum to the SP. A contract for E-mods in the amount of \$15,000 or more must be approved by DOH.

STEP 8 Upon completion of the E-mod, a summary of the work with actual costs, is documented on the Waiver Services Final Cost form by the E-mod provider. The complete form is submitted to the SC who signs off and submits the form to the RRDS.

STEP 9 The RRDS reviews the Waiver Services Final Cost form, and upon approval completes and signs the RRDS Approval of Final Cost form. The RRDS sends a copy of this form to the E-mod provider and SC.

STEP 10 The E-mod provider seeks reimbursement after receiving a copy of the NOD from the SC.

Repairs

Repairs for home modifications which are cost effective may be allowed. Modifications that have worn out through normal use (faucet controls, ramps, handrails, etc.) may be replaced using the same E-mod approval process as for new E-mods. Repair and/or replacement may be contingent upon developing and implementing a plan to minimize repeated damage.

Reimbursement

E-mods must be provided by a DOH approved provider and included in the SP to be reimbursed. E-mods initiated up to thirty (30) days prior to the initial NOD are reimbursed after the Notice is issued.

This service is reimbursed according to the final cost of the project approved by the RRDS and must be less than \$15,000 per twelve (12) month period. If a participant needs more than one type of E-mod during the twelve (12) month period, the combined cost for this period may not exceed \$15,000. A contract for E-mods in the amount of \$15,000 or more must be approved by DOH.

E-mods for Vehicles **This Section is currently under review for revisions**

Home and Community Support Services (HCSS)

Definition

Home and Community Support Services (HCSS) are utilized when oversight and/or supervision as a discrete service is necessary to maintain the health and welfare of the participant living in the community. Oversight and/or supervision may be needed for safety monitoring to prevent an individual from harmful activities (for example wandering or leaving the stove on unattended). Oversight and/or supervision can be accomplished through cueing, prompting, direction and instruction. If the applicant/participant does not require oversight and/or supervision, HCSS would not be appropriate.

HCSS can also be provided to participants needing oversight and/or supervision who also require assistance with personal care services. Personal Care services is defined as some or total assistance with Activities of Daily Living (ADL) such as dressing, bathing, hygiene/grooming, toileting, ambulation/mobility, transferring and eating, and/or Instrumental Activities of Daily Living (IADL) such as housekeeping, shopping, meal preparation, laundry, transportation and telephone use essential to the maintenance of the participant's health and welfare in the community. HCSS can support this as long as the discrete oversight and/or supervision component is needed.

Since HCSS staff must be trained to the Personal Care Aide (PCA) Level, they will be able to perform the scope of personal care tasks and functions necessary for an individual who also requires oversight and/or supervision. The HCSS worker is never allowed to exceed this scope of practice.

HCSS is complementary but not duplicative of other services. HCSS is not to be used as a companion service.

NOTE: If a participant's oversight/supervision needs warrant HCSS during the night, the HCSS staff must remain awake throughout the duration of time assigned to the participant to assure the appropriate level of oversight/supervision is provided.

Once it is determined that a referral for HCSS will be pursued, the applicant/participant should select an HCSS provider from the list of qualified agencies provided by the SC. The SC contacts the selected HCSS provider to request an assessment.

NOTE: If the applicant/participant does not require oversight and/or supervision, he/she may still need to be assessed for assistance with personal care or higher skilled needs. Such assistance may be available from informal supports or a referral to State Plan services may be needed. If the individual appears to need assistance with ADLs and IADLs, the applicant/participant with needs that can not be met through informal supports, must be assessed for personal care services. The SC will need to work with the applicant/participant's physician and LDSS to assure the necessary evaluation is completed and needed services

arranged.

If an applicant/participant's personal care needs are being met through the provision of HCSS under the waiver, that individual cannot receive LDSS prior authorized Personal Care Services. This is true for both the traditional model of LDSS authorized personal care or the Consumer Directed Personal Assistance Program (CDPAP) model.

The RRDS and/or SC may identify that the applicant/participant requires the provision of skilled tasks such as those provided under Certified Home Health Agency services or Private Duty Nursing. These tasks are not included in this waiver service. They are potentially provided to Medicaid recipients through Certified Home Health Agencies (CHHA), Private Duty Nursing or the CDPAP. CDPAP may be used for the delivery of skilled services. In cases involving a combination of HCSS and CDPAP for skilled services, the SC must clearly articulate in the SP the justification of the need for CDPAP and the task(s) CDPAP is providing to the participant.

If an applicant/participant requires HCSS due to the need for discrete oversight and/or supervision, this is an indicator that the individual is not self-directing and requires an appointed self-directed other to manage the CDPAP services. To avoid conflict of interest the individual's HCSS worker, current NHTD waiver service providers, and/or NHTD contract staff (e.g. RRDS, NE and QMS) can not serve as a self-directing other. In addition, any individual associated with an agency delivering Medicaid reimbursed services to the participant can not serve as the self-directing other.

Assessment Process

If the SC determines that the applicant/participant may be in need of HCSS, the SC discusses the need for an assessment by a provider of HCSS with the applicant/participant. The SC provides the applicant/participant with a list of available HCSS providers to select from. Upon selection of the HCSS provider, the applicant/participant completes the Provider Selection form. The SC contacts the selected HCSS provider and forwards the Provider Selection form to that agency. The HCSS provider completes and returns the Provider Selection form to the SC.

The SC completes the designated sections of the Home Assessment Abstract (DSS-3139) (refer to Appendix F) and forwards the tool to the selected HCSS provider's supervising Registered Professional Nurse for completion. Upon receipt of the Home Assessment Abstract (DSS-3139) from the SC, the HCSS provider's Registered Professional Nurse must complete the appropriate nursing-related sections of the Home Assessment Abstract (DSS-3139) and return the completed tool to the SC within (14) calendar days. The Registered Professional Nurse must include in the Home Assessment Abstract (DSS-3139) documentation supporting the need for oversight and/or supervision. In addition, there must be clearly documented recommendations for the amount, frequency

and duration of HCSS for the participant and identification of any additional areas of support needed. The completed assessment tool must be provided to the SC for review with the applicant/participant and to be included in the SP. As per usual practice, the RRDS has the final determination regarding the amount, frequency and duration of HCSS to be provided.

For an applicant/participant who is in a nursing home or hospital at the time the assessment is conducted, the NHTD SC and the selected agency's supervising Registered Professional Nurse will need to complete the Home Assessment Abstract (DSS-3139) tool. For the section of the tool regarding the home environment, it is necessary to access the participant's residence. However, if this can not be done prior to discharge from the hospital or nursing home, it must be completed on the first day HCSS is scheduled to begin. In this situation, HCSS may be approved to begin by the RRDS based on the information available in the preliminary HCSS assessment.

The provider of HCSS must assure that orders from the participant's medical practitioner have been acquired in support of the need for HCSS as approved in the SP. This order must include documentation of the need for oversight and/or supervision as a discrete service based on medical diagnosis.

Other Considerations

Under the NHTD waiver, the selected provider's supervising Registered Professional Nurse will be responsible for supervising HCSS staff. The selected provider's supervising Registered Professional Nurse must conduct an initial home visit on the day and time HCSS staff begins providing services to the participant. The focus of this visit is for the selected provider's supervising Registered Professional Nurse to introduce the staff to the participant, assure services established during the initial assessment continue to be sufficient and, if necessary complete the environmental portion of the preliminary assessment tool. Any changes indicated will be communicated to the NHTD SC and/or MD as appropriate. If a particular activity requires on-the-job training, the selected provider's supervising Registered Professional Nurse will provide it during this visit.

Often times, when HCSS is being utilized, there may be other services involved, for example ILST, and/or Positive Behavioral Intervention and Support (PBIS) and other waiver service providers assisting the participant to work toward his/her goals. For example, if ILST is utilized, an assessment will be completed and a Detailed Plan developed for cueing, prompting or supervising the participant in ADLs and IADLs. The ILST will work cooperatively with the selected provider's supervising Registered Professional Nurse and HCSS staff to assure implementation of the Detailed Plan and provide needed guidance and/or additional training. Another example is the PBIS Specialist who may also train the HCSS staff in behavioral interventions based on a Detailed Plan. The provision of these types of complementary trainings will serve to enhance the level of consistency, cooperation, communication and team work between

providers and the participant.

It is important to consider the interests and needs of the waiver participant when assigning HCSS support. The ability of the HCSS staff to support the strengths, interests and needs of the participant will promote a better working relationship and help to meet the established goals for the service. It is the right of the participant to request a change in HCSS staff. Attempting to find the best match between the HCSS staff and participant from the start decreases the occurrence of staff turnover and Serious Reportable Incidents (SRI) while increasing participant satisfaction and success in the community.

Given the critical need for continuity in oversight and/or supervision, HCSS providers are reminded of their responsibility for assuring sufficient back-up for the HCSS staff.

Provider Qualifications

HCSS may only be provided by a Licensed Home Care Services Agency (LHCSA). All regulations governing the LHCSA will be in effect for the provision of this service, e.g. patient rights, patient service policies and procedures, plan of care, medical orders, clinical supervision, patient care records, governing authority, contracts, personnel, and records and reports.

Key requirements for HCSS staff members include that such staff must:

- Be at least 18 years old;
- Be able to follow written and verbal instructions;
- Have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service;
- Have a certificate to indicate that they have successfully completed a forty (40)-hour training program for Level II PCAs that is approved by DOH;
- Attend the approved DOH curriculum entitled "Home and Community Support Services 101" prior to providing billable services, and any additional training required by DOH;
- Attend six (6) hours of in-service education per year which includes NHTD waiver-specific training; and
- Be in good physical health; including health and immunization requirements as per LHCSA regulations.

The selected provider's supervising Registered Professional Nurse must:

- (a) be licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law and is currently certified to practice as a registered professional nurse in New York State;
- (b) be in good physical health that the Department of Health requires for employees of certified home health agencies that includes documentation of a yearly physical exam, immunizations, a yearly

Mantoux skin test and a declaration that one is free from health impairments which pose potential risks to patients or personnel;
and

- (c) meet one of the following qualifications:
 - (1) have at least two years satisfactory recent home health care experience; or
 - (2) have a combination of (a) and (b), with at least one year of home health care experience and acts under the direction of an individual who meets the qualifications listed in (a) and (b) and (1) of this section.

The HCSS agency must have available a communication system for 24 hours/ seven days per week coverage to assure any issues regarding a participant's services can be addressed.

Reimbursement

HCSS services, including both direct care and selected provider's supervising Registered Professional Nurse Visits, must be provided by a DOH approved provider and included in the SP to be reimbursed.

HCSS services are reimbursed on an hourly basis. When HCSS is provided to more than one person at a time, the ratio of provider to participants must be stated in the SP and the billing must be prorated. Example: HCSS is providing services to two individuals living together for six hours. The SP for each individual reflects a 1:2 ratio and billing reflects three hours per person.

HCSS staff must attend Team Meetings. However, the provider may claim reimbursement for only one agency representative attending a Team Meeting.

The assessment of the applicant/participant for the need for HCSS and providing recommendations for HCSS is considered an administrative cost and, therefore, is not discretely billable. The selected provider's supervising Registered Professional Nurse Visit made on the day the HCSS begins is billable on a per visit basis. This visit will result in the development of the Detailed Plan and if necessary, provide an opportunity for the completion of the environmental section of the preliminary assessment.

Subsequent visits made by the selected provider's supervising Registered Professional Nurse for supervision or on-the-job training of the HCSS staff are considered administrative costs and, therefore, are not billable.

A selected provider's supervising Registered Professional Nurse Visit made six (6) weeks prior to the development of a RSP to re-evaluate the participant for the continued need for HCSS and to complete the Individual Service Report (ISR) is a billable visit.

Home Visits by Medical Personnel

Definition

Home Visits by Medical Personnel are individually designed services to provide diagnosis, treatment and wellness monitoring in order to preserve the waiver participant's functional capacity to remain in his/her own home. Wellness monitoring is critical to the overall health of the waiver participant. Wellness monitoring includes disease prevention, the provision of health education and the identification of modifiable health risks. Through increased awareness and education, the waiver participant is more apt to make healthy lifestyle choices which will decrease the likelihood of unnecessary institutionalization. The frequency of wellness monitoring will be contingent on the waiver participant's needs.

Home visits by Medical Personnel must be needed to decrease the likelihood of exacerbations of chronic medical conditions and unnecessary and costly emergency room visits, hospitalizations and nursing facility placement. In addition to assessing the waiver participant, this service will also include the evaluation of the home environment from a medical perspective and the waiver participant's natural (informal) supports' ability to maintain and/or assume the role of caregiver. The provider's assessment of the natural (informal) supports/caregivers will not be one in which a physical exam is performed; instead the assessment will focus on the natural (informal) supports'/caregivers' relationship to the waiver participant in terms of the physical, social and emotional assistance that is currently provided or may be provided in the future. Based on the outcome of this assessment, the provider of this service can make referrals for or request that the SC make referrals for additional assistance as appropriate, thus promoting the ability of the waiver participant to remain at home. The provision of this service allows the waiver participant to remain in the least restrictive setting. This service will enhance the quality of medical care and the quality of life of the waiver participant.

Home Visits by Medical Personnel differs from what is offered under the State Plan as this waiver service is used for wellness monitoring, the assessment of the natural (informal) supports'/caregivers' ability to provide assistance to the waiver participant, and/or the evaluation of the waiver participant's home environment from a medical perspective.

This service is especially beneficial for those waiver participants who have significant difficulty traveling or are unable to travel for needed medical care provided by a physician, physician's assistant or nurse practitioner because of:

- (1) severe mobility impairments;
- (2) terminal illness;
- (3) when travel is contraindicated due to the person's chronic condition;
- (4) severe pain;
- (5) when medical providers at a physician's office and/or transportation

- providers refuse to provide services due to an individual's disruptive behavior;
- (6) the home visit is cost-effective; or
 - (7) where transportation to medical appointments is limited due to geographical considerations.

The Medical Personnel will perform a comprehensive assessment of the physical, psychosocial, environmental and economic factors in the waiver participant's own environment that could affect the waiver participant's health and welfare and the ability to remain in the community. This comprehensive assessment and medical follow-up in the waiver participant's home is intended to improve the waiver participant's functioning. As a result of this improved functioning, and by having the Medical Personnel complete a comprehensive assessment in the waiver participant's home, the Medical Personnel is more apt to detect conditions in the home environment that negatively affect the waiver participant's health and welfare and respond accordingly. This preventive activity is expected to decrease the likelihood of accidents in the home, lower the waiver participant's and caregiver's stress level, increase the quality of medical care provided to the waiver participant and increase the efficiency of medication management which will promote the waiver participant's ability to remain at home.

As part of the home visit, the medical personnel will evaluate safety issues and other conditions in the home from a medical perspective. Medical Personnel will conduct a basic assessment of the home environment in relation to the waiver participant's health and welfare. Any concerns about the home environment that may affect the waiver participant's health and welfare will be shared with the SC and other relevant members of the team.

The Medical Personnel are an integral part of the waiver participant's service provider team. It is the responsibility of the Medical Personnel to inform the SC of any recommendations for services that will meet the waiver participant's medical needs and other significant findings. The SC will utilize this information in revising the waiver participant's SP.

Provider Qualifications

Home Visits by Medical Personnel must be provided by a Physician in Private Practice or a corporation licensed pursuant to Public Health Law Article 28. Persons providing Home Visits by Medical Personnel shall be a:

1. Physician – Licensed pursuant to NYS Medicine Education Law;
2. Licensed Nurse Practitioner – Licensed pursuant to NYS Education Law; or
3. Licensed Physician's Assistant – Licensed pursuant to Medicine Education Law.

Reimbursement

Home Visits by Medical Personnel must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Home Visits by Medical Personnel are provided on an individual basis and billed in twenty (20) minute units with a maximum of three (3) units per visit.

Home Visits by Medical Personnel providers participating in Team Meetings will be reimbursed at regular rate for attendance at these meetings.

Independent Living Skills Training (ILST)

Definition

Independent Living Skills Training Services (ILST) are individually designed to improve or maintain the ability of the waiver participant to live as independently as possible in the community. ILST assists in recovering skills that have decreased as a result of onset of disability. Also, ILST will primarily be targeted to those individuals with progressive illnesses to maintain essential skills. ILST may be provided in the waiver participant's home and in the community. This service will primarily be provided on an individual basis; only in the unique situation where the waiver participant will receive greater benefit from other than a 1:1 situation, will a group method of providing service be approved.

It is the responsibility of the ILST provider to conduct a comprehensive functional assessment of the waiver participant, identifying the participant's strengths and weaknesses in performing ADL and IADL related to his/her established goals. The Provider will use the results of the assessment to develop an ILST Detailed Plan. The Detailed Plan will identify milestones to be met during the six (6) month period. The assessment must also include a determination of the participant's best manner of learning new skills and responses to various interventions. This comprehensive and functional assessment must be conducted at least annually from the date of the last assessment.

ILST services may include assessment, training, and supervision of an individual with self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, problem solving skills, money management, pre-vocational skills and skills to maintain a household.

ILST must be provided in the environment and situation that will result in the greatest positive outcome for the waiver participant. It is expected that this service will be provided in the waiver participant's environment; for example, in the participant's kitchen as opposed to a provider's kitchen. This expectation is based on the difficulty many participants experience with transferring or generalizing knowledge and skills from one situation to another. However, it is recognized that there is need for some practice of skills before using them in the waiver participant's environment.

ILST services may also be used to assist a participant in returning to, or expanding the waiver participant's involvement in meaningful activities, such as paid or unpaid (volunteer) employment. The use of ILST for vocational purposes must occur only after it is clear that the waiver participant is not eligible for these services through either the Vocational and Educational Services for Individuals with Disabilities (VESID) or the Commission for the Blind and Visually Handicapped (CBVH); that VESID and CBVH services have been exhausted; or the activity is not covered by VESID or CBVH services.

It is expected that ILST providers will train the waiver participant's informal/natural supports, paid staff and waiver providers to provide the type and level of supports that allows the waiver participant to act and become as independent as possible in ADLs and IADLs. This service may continue only when the waiver participant has reasonable goals. It is used for training purposes and not ongoing long term care supports. Reasons to provide or continue this service must be clearly stated in the SP within the context of clearly defined and reasonable goals.

Provider Qualifications

ILST may be provided by any not-for-profit or for profit health and human services agency.

An ILST must be a:

- (A)
 - (1) Registered Occupational Therapist-licensed by the NYS Education Department;
 - (2) Registered Physical Therapist-licensed by the NYS Education Department;
 - (3) Licensed Speech-Language Pathologist-licensed by the NYS Education Department;
 - (4) Registered Professional Nurse-licensed by the NYS Education Department;
 - (5) Certified Special Education Teacher-certified by the NYS Education Department;
 - (6) Certified Rehabilitation Counselor-certified by the Commission on Rehabilitation Counselor Certification;
 - (7) Master of Social Work; or
 - (8) Master of Psychology.

These individuals must have, at a minimum, one (1) year of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities and/or seniors to be more functionally independent; OR

- (B) An individual with a Bachelor's degree and two (2) years of experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities and/or seniors to be more functionally independent; OR
- (C) An individual with a High School Diploma and three (3) years experience completing functionally based assessments, developing a comprehensive treatment plan and teaching individuals with disabilities and/or seniors to be more functionally independent.

The following individuals must be supervised by individuals identified in section (A) to perform ILST services:

- Individuals with the educational experience listed in section (A) but who do not meet the experience qualifications;
- Individual with a Bachelor's degree and one (1) year of experience;
- Individuals with a High School Diploma and two (2) years of experience; and
- Individuals who have successfully completed two (2) years of providing Home and Community Support Services or Residential Habilitation under the Office of Mental Retardation and Developmental Disabilities HCBS waiver.

The supervisor is responsible for:

- Meeting any potential waiver participants prior to the completion of the Detailed Plan developed by the ILST under their supervision;
- Working with the ILST on completing the functional assessment of the participant;
- Working with the ILST to reevaluate the participant as needed, but not less than at the completion of the Revised Service Plans and whenever Addenda to the SP are written;
- Have supervisory meetings with staff on at least a bi-weekly basis;
- Provide ongoing supervision and training to staff; and
- Review and sign-off on all Detailed Plans.

Reimbursement

ILST services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

ILST is reimbursed in one hour units. Participation in Team Meetings is reimbursed at the hourly rate for this service.

If ILST is provided in a group setting, the hourly rate is divided evenly among the participants.

Moving Assistance

Definition

Moving Assistance Services are individually designed services intended to transport a waiver participant's possessions and furnishings. This service can be used when the waiver participant must be moved from an inadequate or unsafe housing situation to a viable environment which more adequately meets the waiver participant's health and welfare needs and alleviates the risk of unwanted nursing home placement. Moving Assistance may also be utilized when the waiver participant is moving to a location where more natural supports will be available, and thus allows the waiver participant to remain in the community in a supportive environment.

Moving Assistance is only available to waiver participants who do not reside in nursing homes. It differs from CTS as CTS is only available to waiver participants who are transitioning from a nursing home. The funding limits for this service are separate and apart from the limits applied to CTS, and the two services must not be used at the same time in any approved SP.

Moving Assistance must be included in the SP and may not exceed \$5,000 per twelve (12) month period. The SC must obtain three bids from licensed moving companies if the bids are over \$1,000. In a unique situation, any requests over \$5,000 per twelve (12) month period must be approved by DOH.

Provider Qualifications

A not-for profit or for profit health and human service agency that provides Service Coordination can be approved to provide Moving Assistance. This does not have to be the same agency providing Service Coordination to the participant. Someone other than the SC may be the individual responsible for arranging Moving Assistance. The Service Coordination agency must designate an individual with the necessary competencies to work with subcontractors who will be utilized for Moving Assistance. The Service Coordination agency will subcontract with licensed certified (by NYS Dept. of Transportation) moving companies to provide this service. A participant may choose from the list of Moving Assistance companies from which they will receive the bids.

Approval Process for Moving Assistance

- Step 1** The participant, SC, and anyone selected by the participant, discuss if a move is necessary;
- Step 2** If necessary, then the participant may choose an approved provider of Moving Assistance;
- Step 3** The Moving Assistance provider works with the participant to select a moving company;

- Step 4** The moving company submits an estimate to the Moving Assistance provider;
- Step 5** If the estimate is under \$1,000, the Moving Assistance provider submits the estimate to the participant's SC;
- NOTE:** If the cost of this service is greater than \$1,000, three (3) bids must be obtained and submitted by the Moving Assistance provider to the participant's SC, along with the Moving Assistance Description and Cost Projection form.
- When the SC determines that the continued delay due to lack of the required number of bids is jeopardizing the participant's health and welfare the SC must contact the RRDS. The RRDS will consult with DOH and will notify the SC if they can proceed without the required three bids;
- Step 6** The SC completes the Moving Assistance Description and Cost Projection form (refer to Appendix C – form C.7), reviews the form with the participant and both the participant and SC sign the form;
- Step 7** If necessary, the SC sends the form to the Moving Assistance provider for their signature and Medicaid provider number;
- Step 8** The Moving Assistance provider returns the completed form to the participant's SC;
- Step 9** The SC submits the completed Moving Assistance Description and Cost Projection form with an Initial or Revised Service Plan, or an Addendum to the RRDS for approval;
- Step 10** The RRDS reviews and approves the costs for the move or makes suggestions before the move is approved;
- Step 11** The RRDS sends a copy of the approved form back to the SC;
- Step 12** The SC notifies the Moving Assistance provider that the participant has been approved for the move;
- Step 13** The Moving Assistance provider completes and signs the Waiver Services Final Cost form (refer to Appendix C – form C.11) with the participant;
- Step 14** The Moving Assistance provider sends the Waiver Services Final Cost form to the SC who signs off and submits it to the RRDS;
- Step 15** The RRDS reviews the Waiver Services Final Cost form and completes the RRDS Approval of Final Cost form. The RRDS provides a copy of the RRDS Approval of Final Cost form to the Moving Assistance provider and SC;

Step 16 The Moving Assistance provider seeks reimbursement after receiving a copy of the NOD from the SC.

Reimbursement

Moving Assistance must be documented in the SP and provided by agencies approved by DOH.

This Service is reimbursed on a cost basis. Total reimbursement for Moving Assistance must not exceed \$5,000 per twelve (12) month period. This may include a ten percent (10%) administrative fee payable to the Moving Assistance provider. Requests above \$5,000 per twelve (12) month period must be approved by DOH.

Nutritional Counseling/Educational Services

Definition

Nutritional Counseling/Educational Services is an individually designed service which provides an assessment of the waiver participant's nutritional needs and food patterns, and the planning for the provision of food and drink appropriate for the waiver participant's conditions, or the provision of nutrition education, and counseling to meet normal and therapeutic needs.

In addition, these services may include:

- Assessment of nutritional status and food preferences;
- Planning for the provision of appropriate dietary intake within the waiver participant's home environment and cultural considerations;
- Nutritional education regarding therapeutic diets as part of the development of a nutritional treatment plan;
- Regular evaluation and revision of nutritional plans; and
- The provision of in-service education to the waiver participant, family, advocates, waiver and non-waiver staff as well as consultation on specific dietary problems of the waiver participants.

Provider Qualifications

Nutritional Counseling/Educational Services may be provided by any not-for-profit or for profit health and human services agency.

Staff providing Nutritional Counseling/Educational Services must be a:

- (1) Licensed as a Registered Dietician – Licensed by the NYS Education Department; or
- (2) Licensed as a Registered Nutritionist – Licensed by the NYS Education Department.

Nutritional Counseling/Educational Services can not be provided to a participant without a physicians' written order which is obtained by the Nutritional Counseling/Educational Services provider. The Nutritional Counseling/Educational Services provider must obtain and maintain all physician's orders in the waiver participant's file at the agency according to existing regulations for Nutritional Counseling.

Reimbursement

Nutritional Counseling/Educational Services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Nutritional Counseling/Educational Services are provided on an individual, per visit basis. In-service education and consultation provided to informal supports or waiver or non-waiver service providers must be included in the SP in order to be reimbursed.

Nutritional Counseling/Educational Services providers participating in Team Meetings will be reimbursed at the per visit rate for their time at the Team Meeting.

Peer Mentoring

Definition

Peer Mentoring is an individually designed service intended to improve the waiver participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community. This is to be accomplished through education, teaching, instruction, information sharing, and self-advocacy training.

The service is based on the belief that often people with disabilities who are struggling to regain a self satisfying life may best benefit from relating to another person with a disability who has been successful in this effort. Since there may be attitudinal and physical barriers placed in the way of individuals with disabilities, a Peer Mentor is able to examine these barriers and assist the waiver participant to overcome them. This service is not intended to meet the waiver participant's needs for a mental health professional's services, which may be necessary due either to a condition which existed prior to the onset of the disabilities or which may have occurred following the onset of the disability. The provider of this service should develop an ongoing relationship with a local provider of mental health services for mutual training, and when appropriate, referral by one entity to the other to assure that waiver participants receive the most appropriate services. The supervisor of the Peer Mentoring service is responsible for assuring that this service is used within the limits described above.

A waiver participant may receive this service as well as CIC or other mental health services as long as the need for both is clearly documented in the Service Plan. This service is provided on an individual basis and specific goals must be established for the individual. Peer Mentoring will primarily be available to waiver participants who have recently transitioned into the community from a nursing home or as needed during times of crisis.

Provider Qualifications

Peer Mentoring may be provided by any not-for-profit or for profit health and human services agency. Persons providing Peer Mentoring must have:

- a significant physical or cognitive disability;
- successfully demonstrated the ability to maintain a productive life in the community; and
- at least one (1) year of paid or unpaid experience providing peer mentoring.

Reimbursement

Peer Mentoring must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Peer Mentoring is provided on an individual, face to face visit on a hourly basis. Participation in Team Meetings is reimbursed at the hourly rate for this service.

Positive Behavioral Interventions and Supports (PBIS)

Definition

Positive Behavioral Interventions and Supports (PBIS) services are individually designed and are provided to waiver participants who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment. The PBIS should be provided in the situation where the significant maladaptive behavior occurs.

PBIS services include but are not limited to:

- A comprehensive assessment of the individual's behavior (in the context of their medical diagnosis and disease progression as determined by the appropriate health or mental health professional), skills and abilities, existing and potential natural and paid supports and the environment;
- The development and implementation of a holistic structured behavioral treatment plan (Detailed Plan) including specific realistic goals which can also be utilized by other providers and natural supports;
- The training of family, natural supports and other providers so they can effectively use the basic principles of the behavioral plan;
- Regular reassessments of the effectiveness of the behavioral treatment plan, making adjustments to the plan as needed.

The primary focus of the Detailed Plan for this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors. None of these activities shall fall within the scope of the practice of mental health counseling set forth in Article 163 of the NYS Education Law.

The Detailed Plan must include a clear description of successive levels of intervention starting with the simplest and least intrusive level. All plans must be written in a manner so that all natural and paid supports will be able to follow the plan.

An emergency intervention plan is warranted when there is the possibility of the waiver participant becoming a threat to him or herself or others.

Provider Qualifications for Director of the Positive Behavioral Interventions Support Program

PBIS services may be provided by any not-for-profit or for profit health and human services agency. The two key positions in PBIS service are the Program Director and the Behavioral Specialist. Each PBIS provider must employ a Program Director.

The Program Director is responsible for assessing the waiver participant and developing the PBIS plan for each waiver participant. The Director may work as a Behavioral Specialist or may provide ongoing supervision to a Behavioral Specialist who will implement the plan.

If a provider has more than one individual who meets the qualifications for Program Director, each of these qualified individuals can develop PBIS plans.

The Program Director must be a:

- (A) Licensed psychiatrist licensed by the NYS Education Department with one year experience providing behavioral services; OR
- (B) Licensed psychologist licensed by the NYS Education Department with one year experience in providing behavioral services; OR
- (C)
 - 1. Master of Social Work;
 - 2. Master of Psychology;
 - 3. Registered Occupational Therapist – Licensed by the NYS Education Department;
 - 4. Registered Physical Therapist - Licensed by the NYS Education Department;
 - 5. Licensed Speech-Language Pathologist - Licensed by the NYS Education Department;
 - 6. Registered Professional Nurse - Licensed by the NYS Education Department;
 - 7. Mental Health Practitioner – Licensed by the NYS Education Department;
 - 8. Certified Rehabilitation Counselor – Certified by the Commission on Rehabilitation Counselor Certification; or
 - 9. Certified Special Education Teacher - Certified by the NYS Education Department.

Each of the individuals in (C) must have, at a minimum, two years of experience providing neurobehavioral services; or

- (D) Individual who has been a Behavioral Specialist for two years and has successfully completed an apprenticeship program offered by the Statewide Neurobehavioral Resource Project.

Provider Qualifications for Behavioral Specialists

The Behavioral Specialist is responsible for implementation of the Detailed Plan under the direction of the Program Director and must be a:

- (A) Person with a Bachelor's Degree;
- (B) Licensed Practical Nurse licensed by the NYS Education Department;
- (C) Certified Occupational Therapy Assistant, certified by the NYS Education Department; or
- (D) Physical Therapy Assistant, certified by the NYS Education Department.

The Behavioral Specialist must have at least one year of experience working with individuals and/or seniors with disabilities or behavioral

difficulties. The Behavioral Specialist must successfully complete forty (40) hours training in behavioral analysis, and crisis intervention techniques which is provided by the Positive Behavioral Interventions and Supports Program. Until the Behavioral Specialist successfully completes the forty (40) hours of training, the PBIS provider may not bill for the Behavioral Specialist's time. The Behavioral Specialist must be supervised by the Program Director. The Program Director will provide ongoing training and supervision to the Behavioral Specialist.

Supervision must occur no less than biweekly to review the caseload and must be more frequent when there is a new participant, new provider or when significant behavioral issues arise.

Reimbursement

Positive Behavioral Interventions and Supports services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

This service is reimbursed on an hourly basis. Participation in Team Meetings is reimbursed according to the hourly rate for this service.

Respiratory Therapy

Definition

Respiratory Therapy is an individually designed service, specifically provided in the home, intended to provide preventative, maintenance, and rehabilitative airway-related techniques and procedures. Respiratory Therapy services include:

- application of medical gases, humidity and aerosols;
- intermittent positive pressure;
- continuous artificial ventilation;
- administration of drugs through inhalation and related airway management;
- individual care; and
- instruction administered to the waiver participant and natural supports.

Provider Qualifications

Respiratory Therapy may be provided by a Certified Home Health Agency licensed under Article 36 of the New York Public Health Law or a provider of Respiratory Therapy and Equipment, and approved as a provider of this waiver service by DOH.

Respiratory Therapy services can not be provided to a participant without a physicians' written order which is obtained by the Respiratory Therapy agency. The Respiratory Therapy provider must obtain and maintain all physician's orders in the waiver participant's file at the agency according to existing regulations for Respiratory Therapy.

Staff providing Respiratory Therapy must be a Respiratory Therapist currently registered and licensed pursuant to Article 164 of the NYS Education Department.

Reimbursement

Respiratory Therapy must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Respiratory Therapy is provided on an individual, per visit basis.

Respiratory Therapy providers participating in Team Meetings will be reimbursed at the per visit rate for their time at the Team Meeting.

Respite Services

Definition

Respite Services is an individually designed service intended to provide relief to natural (informal), non-paid supports who provide primary care and support to a waiver participant. This is usually provided for participants who are in need of oversight and supervision as a discrete task. The primary location for the provision of this service is in the waiver participant's home. Respite Services are provided in a 24-hour block of time.

Services may be provided in another home in the community if this is acceptable to the waiver participant and the people living in the other dwelling. If a waiver participant is interested in seeking a brief respite in a nursing home, this can be accomplished through a Scheduled Short Term Admission, and is not considered a Waiver Service.

Provider Qualifications

Providers of Respite Services must meet the same standards and qualifications as the direct care providers of HCSS. If the services needed by the waiver participant exceed the type of care and support provided by the HCSS, then other appropriate providers must be included in the plan for Respite Services and will be reimbursed separately from Respite Services.

Reimbursement

Respite Services must be provided by a DOH approved provider of HCSS and included in the SP to be reimbursed.

Respite Services are provided in blocks of 24 consecutive hours, billed on a daily-rate basis. Since Respite Services is provided on an intermittent basis, the SC must determine when participation in Team Meetings is appropriate.

Structured Day Program Services

Definition

Structured Day Program services are individually designed services, provided in an outpatient congregate setting or in the community, to improve or maintain the waiver participant's skills and ability to live as independently as possible in the community. Services may include assessment, training and supervision to an individual with self-care, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills, and skills to maintain a household.

Structured Day Program services may be used to augment some aspects of other NHTD services and Medicaid State Plan services when reinforcement of skills is necessary. This is permitted due to the difficulty many individuals have with transferring or generalizing skills learned in one setting to other settings and the need for consistent reinforcement of skills. The SP should address how the services are complimentary but not duplicative and ensure consistency. This service is intended to provide an opportunity for the waiver participant to continue to strengthen skills that are necessary for greater independence, improved productivity and/or increased community inclusion.

The Structured Day Program may be provided within a variety of settings and with very different goals. Waiver participants may choose to participate in a Structured Day Program that emphasizes basic work skills, such as punctuality, problem solving and effectively communicating with co-workers and supervisors. Other Structured Day Programs may focus on specific job skills, such as computer operation, cooking, etc. Other participants, for whom employment is not an immediate or long-term goal, may be more interested in community inclusion or improving their socialization skills.

The Structured Day Program is responsible providing appropriate and adequate space to meet the functional needs of those served. The Program must provide adequate protection for the personal safety of the program participants, including fire drills twice a year and maintain documentation of those drills. The Structured Day Program must be located in a building that meets all provisions of the New York State Uniform Fire Prevention and Building Codes. In addition, access to the Program must meet and adhere to the requirements of the Americans with Disabilities Act. If the RRDS or DOH identifies questionable situations, appropriate referrals will be made for necessary corrective action. The RRDS or DOH may determine the appropriateness of the physical space for the NHTD waiver participants.

Whatever type of Structured Day Program(s) the participant chooses it is essential that there be coordination between providers, assuring consensus in the type of supports and structures that are used in all settings and avoiding

duplication of services. This is particularly important when the participant is receiving waiver services such as ILST, PBIS, and HCSS.

Provider Qualifications for the Director of Structured Day Programs

Structured Day Programs may be provided by any not-for-profit or for profit health and human services agency. All Structured Day Programs must be identified in the SP and provided by agencies approved as a provider of this waiver service by DOH.

The Structured Day Program Director must be:

- (A) (1) Registered Occupational Therapist – Licensed by the NYS Education Department;
- (2) Registered Physical Therapist – Licensed by the NYS Education Department;
- (3) Licensed Speech-Language Pathologist – Licensed by the NYS Education Department;
- (4) Registered Professional Nurse – Licensed by the NYS Education Department;
- (5) Certified Special Education Teacher – Certified by the NYS Education Department;
- (6) Certified Rehabilitation Counselor – Certified by the Commission on Rehabilitation Counselor Certification;
- (7) Master of Social Work; or
- (8) Master of Psychology.

Structured Day Program Directors must have, at a minimum, one (1) year of experience providing functional assessments, Intensive Behavioral Services or Structured Day Program services to individuals with disabilities and/or seniors;
OR

- (B) Individual with a Bachelor's degree and two (2) years of experience providing functional assessments, Intensive Behavioral Services or Structured Day Program services to individuals with disabilities and/or seniors.

In addition to a required Program Director, a Structured Day Program may employ program staff. Program staff must be at least 18 years old; be able to follow written and verbal instructions; and have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service. It is expected that Structured Day Program staff will be available to provide hands-on assistance to participants, and therefore, must have previous training as a PCA.

Reimbursement

Structured Day Program services must be provided by a DOH approved provider and must be included in the SP to be reimbursed.

Structured Day Program services are reimbursed on an hourly basis. Participation in Team Meetings organized by the SC is reimbursed at the hourly rate.

The provision of Structured Day Program services must not occur in a sheltered workshop environment. If a participant decides to make use of the services of a sheltered workshop, the reimbursement for that service must be provided through VESID.

Wellness Counseling Service

Definition

Wellness Counseling Service is an individually designed service intended to assist the medically stable waiver participant in maintaining optimal health status. It is intended to be available to a waiver participant who does not otherwise have access to nursing services. Through Wellness Counseling, a Registered Professional Nurse assists the waiver participant to identify his/her health care needs and provides guidance to the waiver participant to minimize, or in some cases prevent, exacerbations of disease. This service differs from Medicaid State Plan Nursing Service as it provides wellness counseling as a discrete service to medically stable individuals.

Through Wellness Counseling, a Registered Professional Nurse can reinforce or teach healthy habits such as the need for daily exercise, weight control, or avoidance of smoking. Additionally, the Registered Professional Nurse will be able to offer support for control of any diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma or high cholesterol.

In addition to these services, the Registered Professional Nurse can assist the waiver participant to identify signs and symptoms that may require intervention so as to prevent further complications from the disease or disorder. If potential complications are identified, the Registered Professional Nurse will counsel the waiver participant about appropriate interventions including the need for immediate medical attention or contact the waiver participant's physician for referral to traditional Medicaid State Plan services. This service will assess the waiver participant's chronic care needs to assure the participant's health status remains stable and at an optimal level to avoid acute episodes and utilize health care resources efficiently and effectively.

Wellness Counseling Service will be limited to no more than twelve visits in a calendar year and will occur on an as needed basis.

Provider Qualifications

Wellness Counseling Service may be provided by a Certified Home Health Agency or a Licensed Home Care Service Agency. Staff providing Wellness Counseling Service must be a Registered Professional Nurse licensed by the NYS Education Department.

Wellness Counseling Service can not be provided to a participant without a physicians' written order, which is obtained by the Wellness Counseling Service agency. The Wellness Counseling Service provider must obtain and maintain all physician's orders in the waiver participant's file at the agency.

Reimbursement

Wellness Counseling Service must be provided by a DOH approved provider and

must be included in the SP to be reimbursed.

Wellness Counseling Service is provided on an individual, per visit basis. It is limited to no more than twelve visits in a calendar year and will occur on an as needed basis.

Wellness Counseling Service providers participating in Team Meetings will be reimbursed at the per visit rate for their time at the Team Meeting.