Mississippi Department of Rehabilitation Services

Providing the freedom to live

OFFICE OF SPECIAL DISABILITY PROGRAMS

POLICY MANUAL

Title 32: Rehabilitation and Disabilities

Part 1: Office of Special Disability Programs Policy Manual

Mississippi Department of Rehabilitation Services

Providing the freedom to live

MISSION

It is the mission of the Mississippi Department of Rehabilitation Services to provide appropriate and comprehensive services to Mississippians with disabilities in a timely and effective manner.

Service Limitations Waiver

The OSDP Policy and Procedure Manual establishes' guidelines in terms of case service procedures and expenditures. In instances where limitations have been written into policies, OSDP leadership reserves the right to waive any such limitations in order to meet the specific needs of the individual. Any policies other than those set forth by federal and/or state law or regulations are not absolute and may be considered for exceptions or waiver.

Acknowledgment of Receipt

Acknowledgment of Receipt of OSDP Policy and Procedures Manual, manual revisions, policy and/or procedure clarification letters, and any other manual and resource guide information disseminated by MDRS, must be acknowledge within twenty (20) days of the date shown on the transmittal letter by signing and dating the acknowledgment form and submitting that form to your immediate supervisor.

1.0 NONDISCRIMINATION

No individual or group of individuals is excluded from or found ineligible for services on the basis of age, color, creed, gender, national origin, race, religion, or local residence requirement that excludes any individual present in the State who is otherwise eligible to apply for or receive services and discriminate on the type of disability of the individual applying for services.

1.1 CONSUMER AUTHORIZED REPRESENTATIVE

Consumers have the right to appoint a designated representative. The authorized representative is the only person that can authorize the use or disclosure or obtain information on behalf of the consumer.

1.2 INFORMED CHOICE

MDRS provides applicants and clients with opportunities to exercise informed choice throughout the rehabilitation process.

Informed choice is the process by which individuals participating in the rehabilitation process, make decisions about their goals, the services and service providers that are necessary to reach those goals, and how those services will be procured. The decision-making process takes into account the individual's values and characteristics, the availability of resources and alternatives, and general economic conditions. Implementing informed choice requires communicating clearly, gathering and understanding information, setting goals, making decisions, and following through with decisions. To the extent that the individual participates in the procurement of services, implementing choice may also involve basic consumer skills, such as money management and negotiating in the marketplace.

1.3 CLIENT ASSISTANCE INFORMATION

In accordance with the requirements of the Rehabilitation Act Amendments of 1998, MDRS will advise all individuals with disabilities seeking or receiving services through the Department, or their authorized representative, of the availability and purpose of the Client Assistance Program (CAP), including the means to seek CAP assistance. (Authority: 29 U.S.C. Secs. 796c; 34 CFR 364.30)

1.4 ABUSE, NEGLECT, EXPLOITATION OF A VULNERABLE ADULT

It is the policy of MDRS that the persons we serve be treated with dignity and respect at all times. This includes the right to be free from psychological and/or physical abuse, neglect, and/or exploitation. Incidents of abuse, neglect, exploitation will be reported to the appropriate entities.

1.5 CONFIDENTIAL NATURE OF MEDICAL INFORMATION - HIPAA

The Office of Special Disability Programs (OSDP) will abide by the Health Insurance Portability and Accountability Act (HIPAA) guidelines. HIPAA is a federal law that sets additional standards to protect the confidentiality of individually identifiable health information. Individually identifiable health information is information that identifies or could be used to identify an individual and that relates to the:

- Past, present, or future physical mental health or condition of the individual;
- Provision of health care to the individual; or
- Past, present, or future payment for the provision of health care to the individual.

1.6 ACCESSIBILITY OF INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION TO THE CONSUMER

Except as provided elsewhere in this section, if requested in writing by an applicant or eligible individual or representative, MDRS makes all requested information in an individual's record of services accessible to the individual and will release the information to the individual or the individual's representative in a timely manner.

MDRS has established reasonable fees to cover costs of duplicating records or making extensive searches and has established polices and procedures governing access to records.

If duplication of records is requested, by a client or a client's representative, for that client's own use, no fees for reproducing those records shall be charged, unless the volume of such requested information is so extensive as to exceed 20 pages. Should a request for information exceed 20 pages, the Agency employee processing the request shall institute common procedure for such requests by persons authorized to have access to this information by contacting the Office of Finance for the Agency and requesting a "fund number" for receipt of money collected to defray the cost of duplicating the requested records. The employee may then charge the requesting party a fee of $1.00 (one dollar) for each page in excess of 20 pages for the information. Payment should be requested in the form of check or money order, payable to the "Mississippi Department of Rehabilitation Services." When funds are collected, a receipt will be issued to the purchaser. A duplicate receipt will be forwarded to the State along with the check or money order. There will be no charge to State or Federal agencies associated in providing services directed toward the client's rehabilitation program, or any other agencies that have an exchange of information agreement with this Agency.

1.7 RELEASING INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION THAT MAY BE HARMFUL TO THE CONSUMER

Medical, psychological, or other information that MDRS determines may be harmful to the individual may not be released directly to the individual, but must be provided to an individual, which may include, among others, an advocate, a family member, or a qualified medical or mental health professional, unless a representative has been appointed by a court to represent the individual, in which case the information must be released to the court-appointed representative.

1.8 RELEASING INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION OBTAINED FROM OTHER SOURCES

If personal information has been obtained from another agency or organization, it may be released only by, or under the conditions established by, the other agency or organization.

1.9 INACCURATE OR MISLEADING INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION

An applicant or eligible individual who believes that information in the individual's record of services is inaccurate or misleading may request that the designated Agency amend the information. If the information is not amended, the request for an amendment will be documented in the record of services.

1.10 RELEASE OF INFORMATION FOR AUDIT, EVALUATION, AND RESEARCH

Personal information may be released to an organization, agency, or individual engaged in audit, evaluation, or research only for purposes directly connected with the administration of the rehabilitation program or for the purposes that would significantly improve the quality of life for applicants and eligible individuals and only if the organization, agency, or individual assures that:

- The information will be used only for the purpose for which it is being provided.
- The information will be released only to persons officially connected with the audit, evaluation, or research.
- The information will not be released to the involved individual.
- The information will be managed in a manner to safeguard confidentiality; and
- The final product will not reveal any personal identifying information without the informed written consent of the involved individual or the individual's representative.

1.11 RELEASING INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION FOR LEGAL INVESTIGATIONS

MDRS must release personal information in response to investigations in connection with the law enforcement, fraud, or abuse, unless expressly prohibited by Federal or State laws or regulations, and in response to an order issued by a judge, magistrate, or other authorized judicial officer.

MDRS also may release personal information in order to protect the individual or others if the individual poses a threat to his or her safety or to the safety of others.

Notice

When the Agency makes a disclosure to any person or entity other than the client, the following or similar statement shall accompany the disclosure:

NOTICE

THIS IS CONFIDENTIAL INFORMATION FROM THE RECORDS OF THE MISSISSIPPI DEPARTMENT OF REHABILITATION SERVICES. STATE AND FEDERAL LAWS AND REGULATIONS PROHIBIT YOU FROM MAKING ANY FUTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE INFORMED WRITTEN CONSENT OF THE CLIENT FOR WHOM THIS INFORMATION PERTAINS. ANY SUCH FURTHER DISCLOSURE COULD RESULT IN CIVIL OR CRIMINAL LIABILITY.

1.12 RELEASE OF INFORMATION REGARDING DECEASED CLIENT

If information is requested concerning a deceased client, the Agency shall release such information only to the executor of a probate will or the administrator of the estate upon written proof of such status by the court. No other heirs or family members shall be given any information without a court order.

1.13 DISPOSAL OF CASE RECORDS

When disposing of records, care must be taken to prevent inappropriate disclosure of confidential information contained in Agency files. Such files must be shredded, burned, or otherwise destroyed to prevent the unwarranted use of this information.

1.14 NOTICE OF ACTION (HOME AND COMMUNITY BASED WAIVER SERVICES)

The applicant/consumer will be informed in writing of a decision that will result in the following:

- Being determined ineligible for services;
- The amount (quantity) of the service the client will receive;
- The request for particular services being denied;
- Being determined ineligible for continued services;

The Notice of Action shall contain the following information:

- The dates, type, and amount of services requested;
- A statement of the action MDRS/OSDP intends to take:
- A statement of the reason for the action;
- The specific regulation citation which supports the action;
- A complete statement of the consumer/guardian's right to request a hearing;
- The number of days and date by which the hearing must be requested;
- The consumer's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesperson and
- The circumstances under which services will be continued if a hearing is requested;

1.15 ADVANCE NOTICE (HOME AND COMMUNITY BASED WAIVER SERVICES)

Notice of decisions must be given in advance to ensure consumers have the right to appeal. Timelines are set for the use of appropriate interventions and opportunities for conflict resolution through mediation or other techniques before initiating actions to suspend, deny or terminate services. These timelines are as follows:

Advance Notice – The consumer must receive a notice at least 10 (ten) calendar days before the effective date of an action.

Advance Notice Less Than 10 (ten) days – The consumer may be given a notice less than 10 (ten) days before the action will occur if the following occurs:

- There is factual information confirming the death of the consumer;

- The consumer has been admitted to a nursing home;

- The consumer has been admitted to a hospital/institution for more than 30 days;

- Consumer gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information (i.e. states he/she no longer wants services);

- Whereabouts of the consumer are unknown and the post office returns agency mail directed to him indicating no forwarding address;

- Consumer has been accepted for Medicaid services in another state;

- Loss of Medicaid eligibility. The effective date of the action must match the effective date of the termination of Medicaid eligibility.

Advance Notice In Cases of Probable Fraud – A notice may be given to the consumer five (5) days before an action if there are facts that have been verified, if possible, through reliable sources, that there is probable fraud by the consumer.

1.16 HEARINGS AND APPEALS (HOME AND COMMUNITY BASED SERVICES)

Decisions that result in services being denied, terminated, or reduced may be appealed. The consumer/legal representative has thirty (30) days from the date on the notice to appeal the decision. **All appeals must be in writing.**

The consumer/legal representative is entitled to an initial appeal at the local level with the MDRS/OSDP Counselor and the immediate supervisor. The Action will be explained at that time. The local hearing will be documented and become a permanent part of the consumer file.

If the consumer/legal representative does not agree with the decision made following the local hearing, he/she may appeal that decision by requesting a State level hearing within 15 days of the notice of the local hearing decision. The consumer/legal representative must submit this request in writing to the Division of Medicaid. Upon receiving the notification from the Division of Medicaid that the consumer has requested a State level hearing, the OSDP Counselor/District Manger assigned will prepare a copy of the pertinent case file documentation used to reach the decision and send the copy to OSDP in the State Office. The copy of the documentation must be forwarded to the Division of Medicaid no later than five (5) days after MDRS has been notified that the consumer has requested a State level hearing.

The Division of Medicaid will assign a hearing officer. The consumer/legal representative will be given advance notice of the hearing date, time, and place. The hearing may be conducted with all parties involved present, or it may be conducted as a conference call (telephone) hearing. The hearing will be recorded.

The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director of the Division of Medicaid. The Executive Director will make the final determination of the case, and the consumer/legal representative will receive written notification of the decision. The final administrative action, including state or local, will be made within ninety (90) days of the date of the initial request for a hearing. OSDP will be notified by the Division of Medicaid to either initiate/continue or terminate/reduce services.

During the appeals process, contested services that were already in place must remain in place, unless the decision is one of immediate termination due to possible danger or racial or sexual harassment of the

service providers. The OSDP Counselor/registered nurse is responsible for ensuring that the consumer receives all services that were in place prior to their

receipt of the notice that informed them that an action will occur regarding services.

1.17 INELIGIBILITY FOR INDEPENDENT LIVING SERVICES

Whenever it is determined that an applicant for services is not an individual with a significant disability and/or services will not significantly assist the individual to improve his/her ability to function, continue functioning, or move towards functioning in the family or community, there must be a certification of ineligibility. This certification of ineligibility must be dated and signed by the IL Counselor.

The following must be provided:

- The reason for the ineligibility decision. This should be made only after full consultation with the applicant or, as appropriate, his/her parent, guardian, or other legally authorized advocate or representative, or after providing a clear opportunity for consultation:

- The applicant must be notified in writing of the determination;

- The applicant must be informed of his/her rights to express any disagreements with the decision, including administrative review and appeals;

- The individual must be provided with a detailed explanation of the availability and purposes of the Client Assistance Program

- If appropriate, the applicant will be referred to other agencies and facilities, including the VR. (34CFR Sec. 364.51)

1.18 THE FALSE CLAIMS ACT (DEFICIT REDUCTION ACT OF 2005)

The Department of Rehabilitation Services has a strong and continuing commitment to ensure that its services are conducted in accordance with applicable laws relating to all professional practices, third party reimbursement, and contractual and legal obligations. Knowledge of applicable laws that could affect the Department is essential for employees. One such law is the False Claims Act.

The False Claims Act is aimed at the following conduct:

(1) knowingly presenting or causing to be presented a false or fraudulent claim for payment to the government;

(2) knowingly using a false record or statement to obtain payment on a false or fraudulent claim paid by the government; or

(3) engaging in a conspiracy to defraud the government by getting a false or fraudulent claim allowed or paid.

For purposes of the False Claims Act, the terms "knowing" and "knowingly" mean that a person, with respect to information:

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,000 to $10,000 per false claim.

Examples of fraud include, but are not limited to:

- billing for services not rendered;
- requesting, offering, or receiving a kickback, bribe, or rebate;
- using an incorrect or inappropriate provider number in order to be paid;

- selling or sharing patients' Medicare/Medicaid numbers so false claims can be filed;

- falsifying information on applications, medical records, billing statements, and/or cost reports or on any statement filed with the government;

- submitting time and task (services) which were not provided;

- filing a false timelog/authorization/claim;

- submitting false invoice;

- billing for equipment/supplies never ordered;

- billing Medicaid/Medicare for new equipment but providing the client used equipment;

- billing Medicaid/Medicare for expensive equipment but providing the client cheap equipment; and

- charging more than once for the same service.

For more detailed language of the Statute see Appendix 1.

Furthermore, to encourage citizens to report violations, certain protections are in place to shield an individual from retaliation for bringing suit against his or her employer. Any such individual is protected under the "whistleblower" section of the False Claims Act.

1.19 WHISTLEBLOWER

A whistleblower is an individual who makes an initial report to the appropriate government entity or law enforcement that a false claim has occurred or may have occurred.

Additionally, a whistleblower is one who participates in investigations, testimony, or assistance in an action filed or to be filed under the False Claims Act.

WHISTLEBLOWER PROTECTION

The False Claims Act provides protection to individuals whose employer retaliates against him/her because of the employee's participation in an action taken under the False Claims Act. The protection is available to any employee who is terminated, demoted, threatened, harassed or otherwise discriminated against by his or her employer because the employee investigates, files or participates in an action under the False Claims Act.

This "whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee is terminated, and any other damages sustained if the employee is otherwise discriminated against.

1.20 FRAUD/ABUSE

MDRS/OSDP endorses the concept that people who provide services are essentially honest and are entitled to the same protection under the law as all other individuals. However, when there is an indication of potential fraud, the allegations must be investigated.

MDRS/OSDP is responsible for identifying, investigating, and referring cases of suspected fraud or abuse of Medicare or Medicaid.

To help carry out this responsibility, OSDP must be prepared to exclude paying for services when any provider defrauds or abuses the Medicare or Medicaid program.

To determine the existence of fraud and/or abuse, the following must be established:

- intentional misstatement or concealment by direct care worker or vendor created a false impression;
- MDRS/OSDP paid the direct care worker or vendor based on the false impression, when the payment would not have been made if the truth had been known; or
- practices are inconsistent with sound fiscal, business practices, and these inconsistent practices result in unnecessary cost to the program and payment for services that were not provided.

Examples of fraud include, but are not limited to:

- billing for services not rendered;
- requesting, offering, or receiving a kickback, bribe, or rebate;
- using an incorrect or inappropriate provider number in order to be paid;
- selling or sharing patients' Medicare/Medicaid numbers so false claims can be filed;
- falsifying information on applications, medical records, billing statements, and/or cost reports or on any statement filed with the government;
- submitting time and task (services) which were not provided;
- filing a false timelog/authorization/claim;
- submitting a false invoice;
- billing for equipment/supplies never ordered;
- billing Medicaid/Medicare for new equipment but providing the client used equipment;
- billing Medicaid/Medicare for expensive equipment but providing client used equipment;

- billing Medicaid/Medicare for expensive equipment but providing the client cheap equipment; and

- charging more than once for the same service.

1.21 FINGERPRINT AND CRIMINAL BACKGROUND CHECKS

As of July, 1, 2010, in accordance with the requirements of Section 37-33-157, Mississippi Code Of 1972, Mississippi Department of Rehabilitation Services (MDRS) is authorized to fingerprint and perform criminal background checks on persons performing services for or on behalf of the department. This includes a current criminal history record check, child abuse registry check, sex offender registry check, and vulnerable adult abuse or neglect check.

MDRS is authorized to use the results of the fingerprinting and background checks for the purposes of employment decisions and/or actions and service provision to consumers of the department's services.

Specifically, any person who has been convicted of a felony in this state or any other jurisdiction is not eligible to be employed as a personal care attendant (PCA) with MDRS.

Any person subject to registration as a sex offender in this state or any other jurisdiction is not eligible to be employed as a PCA by MDRS.

Any person who has been convicted of certain misdemeanor crimes that could adversely affect the health, safety or welfare of the clients of MDRS is precluded from employment as a PCA.

Additionally, MDRS and its agents, officers, employees, attorneys and representatives shall be exempt from liability for any findings, recommendations or actions taken through the use of the results of the fingerprinting and background checks; and for related purposes.

2.0 RECEIVING REFERRALS

The Office of Special Disability Programs (OSDP) has developed, established, and maintains written standards and procedures to assure expeditious and equitable handling of referrals and applications for services for individuals with significant disabilities.

The staff of MDRS shall process referrals in a timely and appropriate manner. Referrals can be entered into the Automated Case Management System (AACE) by any staff of the agency. OSDP staff should contact referred individuals within 14 (fourteen) days by telephone, letter or personal visit.

3.0 APPLICATION FOR SERVICES

Any individual with a disability can apply for services with the Office of Special Disability Programs (OSDP). The counselor is responsible for completing and reviewing the content of the application with the individual and assuring his/her understanding of the application. If the individual is under the age of 18 or someone who in the best judgment of the counselor, cannot understand the content of the application, then it should be discussed with a parent or legal guardian. A copy of the application should be given to the applicant.

3.1 LONG TERM CARE PRE ADMISSION SCREENING (PAS)

Office of Special Disability (OSDP) clients wishing to apply for services under the following two programs will be required to complete a pre admission screening application (PAS).

- Independent Living Waiver (IL)
- Traumatic Brain Injury/Spinal Cord Injury Waiver (TBI/SCI)

3.2 ESTATE RECOVERY

Federal and state law requires that the Division of Medicaid have an Estate Recovery plan in place. Under this program, the Division of Medicaid becomes a creditor against the estate of a deceased Medicaid recipient under certain conditions. During the initial application process the Counselor must inform the client about Estate Recovery.

Estate Recovery provisions apply to individuals enrolled in Home and Community based Services beginning July 1, 2001.

4.0 DETERMINING ELIGIBILITY FOR INDEPENDENT LIVING SERVICES

Eligibility for Independent Living Services is based upon the following:

- The presence of a significant (severe) physical or mental impairment;

- The presence of serious (severe) limitation(s) in the individual's ability to function independently in the family or community or whose ability to obtain, maintain, or advance in employment is substantially limited;

- The delivery of Independent Living Services will significantly assist the individual to improve his or her ability to function, continue functioning, or move towards functioning independently in the family or community or to continue in employment.

In addition, in order for an applicant or eligible individual to receive services funded through one of the Home and Community Based Waiver (HCBS) programs, certification of eligibility for HCBS must be provided by the Division of Medicaid.

5.0 INITIATION AND DEVELOPMENT OF THE PLAN

Before services are provided a Plan must be jointly developed and mutually agreed upon between the client and Counselor.

6.0 CASE SERVICE RECORD (CLIENT CASE FILE)

The Mississippi Department of Rehabilitation Services**,** Office of Special Disability Programs will establish and maintain a case record for each applicant and/or recipient of services.

Mississippi Department of Rehabilitation Services

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MISSISSIPPI DEPARTMENT OF REHABILITATION SERVICES
OFFICE OF SPECIALTY DISABILITY PROGRAMS

PROCEDURE MANUAL

1.0 APPOINTMENT OF A DESIGNATED REPRESENTATIVE

The consumer or a legally authorized representative for the consumer has the option of designating or changing a designated representative to assist with the responsibilities to assist the consumer in the directing their services. The OSDP Counselor must document the decision on the Appointment of a Designated Representative Form. (See Resource Guide for the Designated Representative Form). Documentation of this should also be maintained in the consumer's electronic case file, AACE.

1.1 DISCLOSURE OF INFORMATION

Confidential Nature of the Consumer Case Record

All information that Mississippi Department of Rehabilitation Services, Office of Special Disability Programs obtains, collects and in possession of MDRS/OSDP to determine eligibility, continue eligibility or directly connected with the administration of programs is confidential.

MDRS/OSDP may disclose general information about policies, procedures, or other methods of determining eligibility, and any other information that is not about or does not specifically identify a consumer.

All information that MDRS has in reference to a consumer or any individual on the consumer's case file is confidential. Confidential information includes, but is not limited to, individually identifiable health information.

Before discussing or releasing information about a consumer or any individual on the consumer's case file, steps should be taken to reasonably be sure the consumer receiving the information is either the consumer or an individual the consumer has authorized to receive confidential information (ex. Personal representative).

Telephone identity outside of a face-to-face contact can be established by an individual who identifies himself as a consumer using his knowledge of the consumer's:

- Date of birth
- Other identifying information

Telephone identity outside of a face-to-face contact can be established by an authorized representative by using their knowledge of the consumer's:

- Date of Birth
- Other identifying information
- The knowledge of the same information about the consumer's representative

Identity of attorneys or legal representatives is established by a completed and signed Authorization for the Use/Disclosure of Protected Health Information form or a document containing all of the following information:

- The applicant/consumer's full name (including middle initial) or full name and either his date of birth or social security number,

- A description of the information to be released,

- A statement specifically authorizing MDRS to release this information,
- The purpose of the release,
- An expiration date of the release and the purpose of the release,
- A statement about whether refusal to sign the release affects eligibility for delivery of services,
- A statement describing the applicant's or consumer's right to revoke the authorization to release information,
- The date the document is signed, and
- The signature of the applicant/consumer.

1.2 RELEASING OR REQUESTING MINIMUM NECESSARY CONFIDENTIAL INFORMATION

OSDP must make reasonable efforts to limit the use or request of individually identifiable health information to the minimum necessary to determine eligibility and administer OSDP programs. OSDP must also make reasonable efforts to limit the disclosure of an individual's case file medical information from MDRS/OSDP records to the minimum necessary to accomplish the requested disclosure.

Information concerning the consumer should only be given to a person who has written authorization from the consumer to obtain the information. The consumer authorizes the release of information to MDRS/OSDP by completing and signing:

- Authorization for the Use/Disclosure of Protected Health Information or;

- A document containing all of the following information:

  - The applicant/consumer's full name (including middle initial) or full name and either his date of birth or social security number,

  - A description of the information to be released,

  - A statement specifically authorizing MDRS to release this information,

  - The purpose of the release,

  - An expiration date of the release and the purpose of the release,

  - A statement about whether refusal to sign the release affects eligibility for delivery of services,

  - A statement describing the applicant's or consumer's right to revoke the authorization to release information,

  - The date the document is signed, and

  - The signature of the applicant/consumer.

1.3 PRIVACY NOTICE

MDRS/OSDP staff must send each consumer a Notice of Privacy Practices and Acknowledgement of Receipt of Notice, upon application. This form tells the consumer about:

- His privacy rights;
- The duties of MDRS/OSDP to protect health information; and

How MDRS/OSDP may use or disclose health information without his authorization. (Example: Medicaid, Medicare, reporting victims of abuse, law enforcement purposes, sharing with vendors, and coordinating other programs that provide benefits.)

1.4 RELEASING INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION, WHEN AN EMPLOYEE IS SUBPOENAED

If an employee of the Agency is subpoenaed for appearance in court, by law the employee must appear at the time and place indicated in the subpoena. **Unless specific records are subpoenaed, no files or records should be taken into the courtroom**. When a client is involved in litigation or in an administrative proceeding and a subpoena for the production of only the client's records is received by the Agency, the employee receiving it shall do as follows:

- Contact their immediate supervisor for assistance; and,
- The subpoenaed employee shall do the following:
- If the subpoena is from the client's attorney, contact the attorney immediately and request written confirmation or his/her status as the client's attorney.
- If the subpoena is from an attorney other than the client's, contact the client's attorney, if known, for the information, and release the information only after such consent is received.
- If the subpoena is received and the consent has not been received by the due date of the subpoena, the employee shall appear before the court or administrative body and inform them of the requirements by law and regulations concerning confidentiality. The employee shall testify only upon order, or if the client consents, at the hearing.
- If an employee receives a subpoena to testify in court or in an administrative hearing, the employee shall appear according to the terms of the subpoena, and shall testify if the client consents to such testimony. If no consent is given, the employee shall testify only under order and after informing the court or administrative body of the requirements of the law and regulations concerning confidentiality and only testify about general information.
- Concerning the Agency such as services available and eligibility criteria

This section applies only to client records. The employee may testify without client consent about general information concerning the Agency, such as services available and eligibility criteria.

If an employee of the Agency is required to give sworn testimony, the employee should limit his/her remarks to the professional aspects of the case with which the employee is familiar and avoid unsubstantiated personal opinions. If travel expense is required in order to present testimony, travel costs are usually paid by the court or by the parties in litigation. If no other reimbursement is provided, the employee may claim reimbursement in keeping with Agency regulations.

1.5 COPYING CASE FILE RECORDS

MDRS has established reasonable fees to cover extraordinary costs of duplicating records or making extensive searches and has established policies and procedures governing access to records.

If duplication of records is requested by a client or his/her personal representative for that client's own use, no fees for such reproduction of those records shall be charged unless the volume of such requested information is so extensive as to exceed 20 pages. Should a request for information exceed twenty pages, the Agency employee processing the request shall institute common procedure for such request by persons authorized to have access to this information by contacting the Office of Finance for the Agency and requesting a "fund number" for receipt of money collected to defray the cost of duplicating the requested records. The employee may then charge the requesting party a fee of $1.00 (one dollar) for each page in excess of 20 pages for the information. Payment should be requested in the form of a check or money order, payable to the "Mississippi Department of Rehabilitation Services." When funds are collected, a receipt will be issued to the purchaser. A duplicate receipt will be forwarded to the State Office along with the check or money order. There will be no charge to State or Federal agencies associated in providing services directed toward the client's rehabilitation program, or any other agencies that have an exchange of information agreement with this Agency.

1.6 CUSTODY OF RECORDS

OSDP Staff must use reasonable diligence to protect and preserve records. Consumer case files must be safeguarded to prevent disclosure of information they contain, except in circumstances provided by MDRS/OSDP policy.

To help safeguard and use reasonable diligence for case files, the case files and information should be:

- In a locked office when the building is closed,
- Properly filed during office hours, and
- In the office at all times, except when authorized to remove or transfer them.

1.7 CASE SERVICE RECORD RETENTION

Federal and State regulations require the retention of closed consumer files for a period of three years beginning with the date of the submission of the final expenditure report for the year during which the case was closed. The Division of Medicaid requires maintenance of record for a period of five (5) years. ***MDRS/OSDP will retain all case files for five (5) years***.

If any litigation, claim, negotiation, audit, or other actions have been initiated before the expiration of the three-year period, the records will be retained until the completion of the action and resolution of all issues which arise or until the end of the regular five-year period, whichever is later.

All offices will be notified when the records of a particular year will be retained for the purpose of resolving any action initiated prior to the expiration of the five-year period.

The following situations may also require records to be retained longer than five (5) years from closure.

- Applicants closed from application status – Records must be retained for at least five years after the last annual review.

- Consumers closed from service status – Records must be maintained for at least five years after the last annual review.

- Applicants or consumers who received a Fair Hearing – Records must be maintained for at least five years after a final determination is made.

1.8 GEOGRAPHIC TRANSFER AND FILE TRANSFER

A consumer who moves from one geographic area to another is automatically transferred to the IL Counselor for that area. For waiver cases, all points of waiver eligibility must continue to be met. As soon as the "sending" Counselor learns that a move is planned, the Counselor must contact the "receiving" Counselor on behalf of the consumer to share information, discuss availability of PCA's in the area if needed, and aid continuity of receiving services prior to transferring the case. Notification should be in the form of e-mail or phone call. The current Counselor must share information regarding the new Counselor with the consumer and PCA's, if needed, to assist in making an informed decision in regard to the anticipated move.

A transfer summary should then be completed in AACE case notes. The transfer summary should include a brief summary of the services that have been provided and plans or intent of future services.

The District Manager should be notified by e-mail of the date the case is to be transferred to the receiving Counselor and the District Manager will complete the transfer in AACE.

The "sending" Counselor must provide the "receiving" Counselor with the consumer's entire original case file within seven (7) working days.

The "sending" Counselor will forward notification of a change in location to the District Manager, and the District Manager will forward this information to the Medicaid Reimbursement Officer.

OSDP Administrative staff will notify the Division of Medicaid of the location change.

Upon receipt of the case file, the "receiving" Counselor will date stamp the outside of the case file to indicate the date received.

Within 14 calendar days of the transfer effective date, the receiving Counselor must contact the consumer by phone or personal visit to review the POC/ILP for services currently in effect.

Note: *If a case is closed and information from that closed case is requested by another Counselor, the closed case cannot be transferred. A copy of pertinent information will be made and mailed to the requesting Counselor.*

1.9 OPPORTUNITY TO REGISTER TO VOTE

The National Voter Registration Act of 1993 requires that MDRS assist clients and applicants in registering to vote.

At the time of application, at annual re-certifications, change of address or when requested, applicants/clients must be given the opportunity to:

- Complete the mail-in Voter Registration Application at home and mail it in, or
- Leave the completed form with MDRS staff.
- Complete the portable Voter Registration Form online at:

  www.sos.state.ms.us/elections/voterregistration

  See Resource Guide for a copy of the Mississippi Voter Registration Application.

If the client wishes to complete the form during the interview, review the form for completeness in the presence of the client. If it does not contain all the required information and/or the required signature, return it to the client for completion.

MDRS must transmit the form to the appropriate county voter registrar within five (5) days of receipt.

If the applicant or client is not of voter registration age, do not complete the voter registration form.

The Counselor must document any action when the client asks to register to vote in the case file. If they have any questions regarding voter registration process, advise them to call:

- The Secretary of State's office at: 601-359-1350.
- Give them the phone no. to their local county voter registration Office.

If the client acknowledges they are not a United States citizen or records in case file reflect they are a non-citizen, MDRS is not required to offer them the opportunity to register to vote.

1.10 MEASURES FOR DETECTING AND PREVENTING WASTE, FRAUD AND ABUSE

The following procedures are used to detect and prevent waste, fraud and abuse:

- The Case Management Verification Report is used to verify that monthly contacts, quarterly review visits and recertification visits are completed each month. The report further is used to check time logs received for the month against the number of hours the personal care attendant is approved for;

- For clients who are eligible for Medicare or Medicaid and have any other third party resources, the OSDP Counselor must explore all available benefits. The OSDP Counselor must document any available benefits in the case file. All comparable benefits and third party resources are explored and utilized prior to authorizing for client services;

- The MDRS Program Evaluation Division conducts case file audits; and,

- The Assistive Technology Delivery Receipt is signed by the client to verify recommended equipment is received as ordered. The original form is maintained in the case file.

1.11 UTILIZING COMPARABLE BENEFITS (THIRD PARTY RESOURCES)

For clients who are eligible for Medicare or Medicaid, the Counselor must explore the availability of services through other programs before assuming that the only resource is IL Waiver, TBI/SCI Waiver, IL Grant or TBI/SCI Trust fund. Any available benefits must be documented in the case file and utilized before any other program funds are used to meeting the individual's needs. For the waiver, these services are considered non-waiver services.

Example: If the client is eligible for Medicare and needs some type of equipment/supplies, the services available through Medicare must be used before using other OSDP programs to provide the services.

The Counselor is responsible for assisting the client in utilizing all other available services.

Other non-waiver services can include personal attendant care services provided by family or friends, or other community resources, skilled care or services provided by other agencies.

The provision of waiver and non-waiver must be a cooperative or collaborative effort between the Counselor and other resources.

When services are received by other resources, the amount of the service planned on the POC/ILP will be reduced by the amount available for that purpose through non-waiver funds.

The Counselor must make efforts to obtain documentation (copies) from the client, the family, or the resource providing funding and services to document what services will be provided and through what resources. If documentation is not available, a summary of the services provided by other resources must be documented in the case file and the Counselor can proceed with developing the POC/ILP.

1.12 VERIFYING THE AVAILABILITY OF THIRD PARTY RESOURCES (INSURANCE)

The Counselor must obtain information regarding the availability of insurance or other comparable resources beginning at application. This information must be documented on the Application for Services/Initial Intake Interview form.

Information that is usually needed by the Counselor/vendor to pre-certify and coordinate benefits is:

- Policyholder's name and Social Security number,
- Group number,
- Diagnosis and prognosis,
- Beginning and end dates, total days of service, and/or type of service requested

1.13 ORDERING POSTAGE

Postage should be requested for a 3 month period. Copy of a blank "Statement of Account" form is used for ordering postage. The original and three copies of the statement of account should be signed by the Counselor and forwarded to the District Manager for approval.

Upon approval, the original and two copies will be sent to Finance and one copy will be left in the District Manager's office. (See Statement of Account form).

1.14 ORDERING OFFICE SUPPLIES

When ordering supplies, the original order form and two copies should be sent to the District Manager for approval. The original and one copy will then be forwarded to Finance. The District Manager will keep a copy for his/her files.

When an item is not on the approved supply list, a FIN-1 form requesting specific items should be completed. The District Manager may require a copy of the signed purchase order for his/her records.

Once the item ordered on a FIN-1 has been received, a copy of the signed purchase order will need to be sent to the district office.

2.0 RECEIVING AND SCREENING INDIVIDUALS REQUESTING SERVICES

The initial request for services may be made by:

- potential consumer
- relative
- hospital
- nursing facility staff
- physician
- friend, etc.

The OSDP staff must determine if the referral is appropriate.

The OSDP staff must review the referral for key information necessary for eligibility determination:

- Appears to be financially eligible for waiver services?
- Medicaid status (Check Envision)
- Appear to meet the medical criteria for waiver services?

2.1 INFORMATION TO BE DISCUSSED WHEN CONTACTING A REFERRAL

The Counselor makes an initial contact with the applicant and an appointment is scheduled. When contact is made with the referral, the Counselor will complete/discuss the following:

- Explain basic eligibility requirements;
- Explain services/option available, and
- Confirm their desire to continue with the application process
- Review and discuss their rights and responsibilities
- Review and discuss eligibility criteria and responsibilities
- Obtain information about financial eligibility. Is the client currently receiving Medicaid?
- Present and review information about Medicaid Estate Recovery Program and document this was presented and discussed
- Obtain information about third-party resources (Comparable Benefits) including if they are receiving Home Health thru Medicare and other formal and informal support systems

2.2 SCREENING REFERRALS FOR SPECIFIC OSDP PROGRAMS

The staff member accepting the initial referral must determine what program such as TBI/SCI Trust fund, TBI/SCI Waiver, State Attendant Care, Independent Living Waiver or IL Grant, should be reflected on the referral based on the information received.

Individuals should be informed of the services available through all programs and the current availability of specific programs including referral list procedures, if applicable.

If an individual requests to be placed on the HCBS Referral List after being informed of eligibility criteria, whether or not he/she appears eligible, the individual must be placed on the Referral List.

If an individual is requesting services that only a specific program can address such as Personal Care Attendant Services, the program that provides that service must be checked on the referral so that the consumer will be placed on that Referral List.

2.3 RELEASING REFERRALS FROM THE REFERRAL LIST

Referrals for OSDP Programs are placed on the Referral List based on the date of their request for services. As allocation allow, referral names will be released from the Referral List for individuals requesting services via the IL Grant, State Attendant Care Program, TBI/SCI Trust fund Program, IL Waiver and TBI/SCI Waiver. On the date the referral is released, all referrals released will be assigned to an OSDP Counselor for the area in which the individual will be served.

When a referral is released, the OSDP Counselor must contact the referral within 14 days.

MDRS/OSDP will maintain a separate Referral List for individuals requesting services from the following programs:

- Independent Living Waiver
- TBI/SCI Waiver
- State Attendant Care
- TBI/SCI Trust fund
- IL Grant

All referrals received are:

- entered into the AACE Referral Database

All referrals are entered based on:

- the minimum amount of information that must be gathered in order to place the individual in the referral database

All referrals are organized by:

- the date of referral with the oldest date at the top of the list and the most recent date at the bottom of the list.

Any referral can apply for services when:

- their name comes to the top of the list and;
- a waiver slot is available (IL Waiver; TBI/SCI Waiver)
- MDRS/OSDP has funding available to support the slots that have been federally approved.
- when funding is not available to support the slots that are not full, referrals of potential consumers will remain a referral until a slot becomes available.

2.4 REFERRALS FOR INDIVIDUALS TEMPORARILY OUT OF THEIR COUNTY OF RESIDENCE

The OSDP Counselor responsible for the county in which the individual resides handles the application process for the individual. If the person is temporarily not in the county of residence, the application will be processed by the Counselor responsible for the area where the individual is temporarily located. The OSDP Regional Manager for the applicant's county of residence may ask the Regional Manager for the county where the individual is temporarily located to initiate the processing of the application and to forward the information obtained to the OSDP Counselor that serves the applicant's county of residence.

Activities that might be expected of the Counselor in the county where the individual is temporarily located include, but are not limited to:

- Interviewing the consumer or responsible party;
- Assisting the consumer or responsible party in completing the application process;
- Arranging for an initial assessment
- Obtaining medical documentation such as Physician Certification, medical documents that indicate diagnosis, TBI/SCI Verification document, etc.
- Discussing with Social Workers, etc. the services the consumer will need;
- Forwarding information obtained to, and/or informing, the OSDP Counselor that will receive the case, information that has been received regarding their request for services; and
- Performing activities that the two Counselors have agreed upon.

The OSDP Counselor for the county in which the individual will reside is responsible for the overall determination if the applicant is eligible and is responsible for initiating services following the development of the ILP and/or certification for the waiver.

The Counselor that serves the county in which the individual will reside may choose, after review with the Regional Manager, to handle the entire application process without involving any other OSDP Counselor that covers the county in which the individual is currently in.

Example: Client currently in hospital in Hinds County but resides in Harrison County

Example: Client currently living in Hinds County with family, but will return to live at his home in Calhoun County.

2.5 REFERRALS/APPLICANTS WHO WANT TO REQUEST/APPLY FOR INDEPENDENT LIVING WAIVER OR TBI/SCI WAIVER WHILE RESIDING IN A NURSING FACILITY

Any individual who is residing in a nursing facility (NF) and is wanting to transition from the NF to the home and community may request and apply for services through the Independent Living Waiver or TBI/SCI Waiver.

The individual will have their name placed on the Independent Living Waiver or TBI/SCI Waiver Referral List.

The individual can apply for services when:

- Their name comes to the top of the list and;
- A waiver slot is available and;
- MDRS/OSDP has funding available to support the slots that are federally approved.

The individual must reside in the nursing facility (NF) until a final determination is made indicating certification for the Independent Living Waiver or TBI/SCI Waiver unless they are transitioning on another OSDP Program.

2.6 TRANSITIONING FROM NURSING FACILITY ON WAIVER PROGRAM

Counselors must strongly stress to referrals the importance of remaining in the nursing facility until they receive notification of certification from the Counselor for home and community-based services. If the individual leaves the nursing facility prior to notification of certification by MDRS, their name will be put on the IL Waiver or TBI/SCI Waiver Referral List based on the date of referral.

If they are currently an applicant for waiver services and leaves the nursing facility prior to notification of certification for home and community – based services, services will not begin until a certification date is received.

2.7 INFORMATION AND REFERRAL

The Mississippi Department of Rehabilitation Services, Office of Special Disability Programs has an information and referral system in place. This system provides individuals with disabilities:

- information about services;
- refer individuals to other services and programs.

3.0 PROGRAM OVERVIEW – INDEPENDENT LIVING WAIVER (IL)

Legal Basis

The statutory basis for this program is Section 1915 c (7) (B) of the Social Security Act.

Independent Living Waiver

The Independent Living Waiver (IL) program provides home and community-based services to individuals who have severe orthopedic and/or neurological impairments and who would qualify for nursing facility (NF) care.

The goal of the Independent Living Waiver program is to provide individuals with a meaningful choice regarding long-term care services. This goal is accomplished by facilitating the development and utilization of services that allow individuals to avoid premature nursing facility (NF) placement and provide current NF residents an opportunity to return to the home and community.

Individuals receive services though the IL Waiver and through other non-waiver service providers that are necessary to provide a safe alternative to nursing facility (NF) placement. The Independent Living Waiver allows Mississippi to provide services that are not available under the regular Medicaid State Plan program.

3.1 PROGRAM OVERVIEW – TRAUMATIC BRAIN INURY/SPINAL CORD INJURY WAIVER (TBI/SCI)

The Traumatic Brain Injury/Spinal Cord Injury Waiver provides individuals with an array of services as identified by the Case Management Team (OSDP Counselor and Registered Nurse) and identified on the Plan of Care (POC) necessary to allow the individuals with traumatic brain injury and/or spinal cord injury to remain in or return to a community setting.

Services are provided by MDRS/OSDP, providers/contractors/vendors for MDRS/OSDP and Division of Medicaid.

3.2 PROGRAM OVERVIEW – TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY TRUST FUND (TBI/SCI)

The goal of this program is to enable individuals severely disabled by a traumatic spinal cord injury or traumatic brain injury to resume the activities of daily living and reintegrate into the community with as much dignity and independence as possible. For those persons who cannot achieve complete independence, supportive services are needed in order for them to live as normally as possible.

The Trust Fund is the payer of last resort. An individual must seek the assistance from all available resources prior to the Trust Fund's participation.

3.3 PROGRAM OVERVIEW – FEDERAL INDEPENDENT LIVING GRANT INDEPENDENT LIVING SERVICES (TITLE VII)

MDRS receives a federal grant from the Rehabilitation Services Administration (RSA) to assist individuals with the most severe disabilities to become more independent in their homes and communities. Although there are no age restrictions for this program, services provided must not duplicate services allowable under any other federal mandate.

3.4 PROGRAM OVERVIEW – STATE ATTENDANT CARE PROGRAM

In 1985, the Mississippi Legislature created the State Attendant Care Fund. This state funded program provides personal care assistance services such as bathing, toileting, meal preparation, eating, and dressing to individuals with the most significant/severe disabilities. There are no age restrictions for this program; however, individuals must be able to direct their own care and must not be eligible for personal care assistance through any other program. The provision of a Personal Care Attendant allows an individual to function as independently as they can in the home and community.

4.0 INDEPENDENT LIVING WAIVER PROGRAM SERVICES

The Independent Living Waiver provides individuals with severe orthopedic and/or neurological impairments an array of services as identified by the Case Management Team (OSDP Counselor and Registered Nurse) and identified on the Plan of Care (POC) necessary to allow the individual to remain in or return to a community setting.

Services are provided by MDRS/OSDP, providers/un-paid resources/vendors for MDRS/OSDP and Division of Medicaid.

Brief description of Independent Living Waiver services are:

1. **Case Management –** activities that assist the consumer in gaining access to waiver services, non-waiver services from other resources or other OSDP Programs

2. **Personal Care Attendant Services –** assistance a consumer receives with the performance of the activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment.

3. **Specialized Medical Equipment and Supplies –** devices, controls, appliances or medically necessary supplies that increase a consumer's ability to perform his activities of daily living; perceive, control, and communicate with the environment in which they live;

4. **Transition Assistance Services –** assistance a consumer receives with transitioning from a nursing facility to the Independent Living Waiver program.

5. **Environmental Accessibility Adaptations -** services that assess the need for, arrange for, and provide modifications to an individual's home to enable him/her to reside in the home and to ensure safety, security, and accessibility.

4.1 TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY WAIVER SERVICES

Brief description of Traumatic Brain Injury/Spinal Cord Injury Waiver services are:

1. **Case Management –** activities that assist the consumer in gaining access to waiver services, non-waiver services from other resources or other OSDP Programs

2. **Personal Care Attendant Services –** assistance a consumer receives with the performance of the activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment.

3. **Specialized Medical Equipment and Supplies –** devices, controls, appliances or medically necessary supplies that increase a consumer's ability to perform his activities of daily living; perceive, control, and communicate with the environment in which they live;

4. **Transition Assistance Services –** assistance a consumer receives with transitioning from a nursing facility to the Independent Living Waiver program.

5. **Respite Services –** short term, temporary relief to the usual caregiver because of the absence or need for relief of the caregiver. Provides all the necessary care the usual caregiver would provide during that time period to the individual.

6. **Environmental Accessibility Adaptations -** services that assess the need for, arrange for, and provide modifications to an individual's home to enable them to reside in the home and to ensure safety, security, and accessibility.

4.2 TBI/SCI INJURY TRUST FUND SERVICES

1. Transitional Personal Care Attendant Services

Attendant care services to assist an individual with physical activities of daily living such as bathing and grooming or cognitive activities such as planning daily schedules or participating in community reintegration activities.

Limitation: Twelve-month limit on transitional attendant care.

During this twelve-month lifetime period, the client and the Counselor should make every effort to explore other attendant care options.

Time allotments will range between two and four hours per day except where unusual needs exist. Case file should be documented to support the need for additional hours.

2. Durable Medical Equipment

An assessment/evaluation for this service will not be counted towards an individual's lifetime cap.

3. Home Modifications

Follow the guidelines and procedures to purchasing Durable Medical Equipment and Assistive Technology Services Section 13.

4. Vehicle Modifications

Follow the guidelines and procedures to purchasing Durable Medical Equipment and Assistive Technology Services Section 13.

NOTE: Life CAP for Durable Medical Equipment, Home Modifications and Vehicle Modifications combined is $35,000 per individual lifetime.

5. **Respite Services -** A temporary, short-term furlough of a family member(s) or other caregiver from the responsibility of oversight and personal care for a survivor of spinal cord or brain injuries.

   Limitation: **An individual is allowed a maximum of 288 respite hours per year which is scheduled at the discretion of the survivor and regular caregiver.**

6. **Emergency Services –** Emergency services are services provided to

the individuals that are of a short-term urgent nature and are considered critical for the individual's survival, general health, and welfare. There is a $1,000 lifetime cap limitation per individual.

4.3 STATE ATTENDANT CARE SERVICES

Brief description of the State Attendant Care services is:

1. **Case Management –** activities include monthly contacts with the client, annual assessments, certification of the Personal Care Assistant and check financial status of clients each year. Also provide access to other resources or other OSDP Programs.

2. **Personal Care Attendant Services –** assistance a consumer receives with the performance of the activities of daily living and household chores necessary to maintain the home in a clean, sanitary, and safe environment.

4.4 INDEPENDENT LIVING GRANT SERVICES

A) **Advocacy/Legal Services** – Assistance and /or representation in obtaining access to benefits, services, and programs to which a consumer may be entitled.

B) **Assistive Technology** – Any assistive technology device, that is, any item, piece of equipment or product system that is used to increase, maintain or improve functional capabilities of individuals with disabilities and any assistive technology service that assists an individual with a disability in the selection, acquisition or use of an assistive technology device.

C) **Children's Services** – The provision of specific IL services designed to serve individuals with significant disabilities under the age of 14.

D) **Communication Services** – Services directed to enable consumers to better communicate, such as interpreter services, training in communication equipment use, Braille instruction, and reading services.

E) **Counseling and Related Services** – These include information sharing, psychological services of a non-psychiatric, non-therapeutic nature, parent-to-parent services, and related services.

F) **Family Services** – Services provided to the family members of an individual with a significant disability when necessary for improving the individual's ability to live and function more independently, or ability to engage or continue in employment. Such services may include respite care. Record the service in the consumer's CSR on behalf of whom services were provided to the family.

G) **Housing, Home Modifications, and Shelter Services** – These services are related to securing housing or shelter, adaptive housing services (including appropriate accommodations to and modifications of any space used to serve, or occupied by individuals with significant disabilities).

H) **<u>IL Skills Training and Life Skill Training Services</u>** – These may include instruction to develop independent living skills in areas such as personal care, coping, financial management, social skills, and household management. This may also include education and training necessary for living in the community and participating in community activities.

I) **<u>Information and Referral Services</u>** – Identify all individuals who requested this type of assistance. This is the only service (other then services to family members) that may be provided to all individuals, whether or not the individual has a disability. Some entities record this service using strokes on an answering pad without opening a CSR, others create a CSR or other such file for future contact and outreach.

J) **<u>Mental Restoration Services</u>** – Psychiatric restoration services including maintenance on psychotropic medication, psychological services, and treatment management for substance abuse.

K) **<u>Mobility Training Services</u>** – A variety of services involving assisting consumers to get around their homes and communities.

L) **<u>Peer Counseling Services</u>** – Counseling, teaching, information sharing, and similar kinds of contact provided to consumers by other people with disabilities.

M) **<u>Personal Assistance Services</u>** – These include, but are not limited to, assistance with personal bodily functions; communicative, household, mobility, work, emotional, cognitive, personal, and financial affairs; community participation; parenting; leisure; and other related needs.

N) **<u>Physical Restoration Services</u>** – Restoration services including medical services, health maintenance, eyeglasses, and visual services.

O) Preventive Services – Services intended to prevent additional disabilities,
or to prevent an increase in the severity of an existing disability.

P) Prostheses, Orthotics, and Other Appliances – Provision of, or assistance
in obtaining through other sources, an adaptive device or appliance to
substitute for one or more parts of the human body.

Q) Recreational Services – Provision or identification of opportunities for the
involvement of consumers in meaningful leisure time activities. These may
include such things as participation in community affairs and other
recreation activities that may be competitive, active, or quiet.

R) Rehabilitation Technology Services – Any service that assists an
individual with a disability in the selection, acquisition or use of applied
technologies, engineering methodologies or scientific principles to meet the
needs of the individual and address the barriers confronted by individuals
with significant disabilities with respect to education, rehabilitation,
employment, transportation, IL and/or recreation.

S) Therapeutic Treatment – Services provided by registered occupational,
physical, recreational, hearing, language, or speech therapists.

T) Transportation Services – Provision of, or arrangements for,
transportation.

U) Youth/Transition Services – Any service that develops skills specifically
designed for youth with significant disabilities between the ages 14 and 24

to promote self-awareness and esteem, develop advocacy and self-
empowerment skills and career exploration, including the transition from
school to post school activities such as postsecondary education, vocational
training, employment, continuing and adult education, adult services,
independent living or community participation.

V) <u>Vocational Services</u> – Any services designed to achieve or maintain
employment.

W) <u>Other Services</u> – Any IL services not listed above in A-V.

5.0 APPLICATION FOR INDEPENDENT LIVING SERVICES (ILS)

The Application for Services form and the Statement of Understanding form must be completed on all applicants who wish to apply for services under the Office of Special Disability Programs. Once completed, this form should be filed in the client case file in the appropriate tab. See Resource Guide for Application For Services Form and the Statement of Understanding Form.

The Application Documentation

The Application Documentation Page that is a part of the Application for Services is very important to the overall case process. This information lays the foundation of the entire casework process.

Documentation

Reasons for seeking services:

In this section, the Counselor should record information that they received during the initial application process regarding the individual's disability and their medical history to help the Counselor determine what medical or other information should be requested. The history of the individual's adjustment or lack of adjustment to their impairment is very important and their family support system.

Describe their independent living needs:

The Counselor should document the problems the applicant is having and what services they are requesting to enable them to function more independently in the home and community.

6.0 PRE-ADMISSION SCREENING (PAS) DETERMINATION REQUIREMENTS

The new Pre-Admission Screening process became effective on October 1, 2007. All applicants/clients applying for Medicaid long term care on October 1, 2007 and beyond must complete a Pre-Admission Screening (PAS) for clinical eligibility determination. The PAS must be submitted within thirty (30) days of the physician's certification.

Individuals enrolled in Medicaid long term care must be recertified annually. Clients desiring continued waiver services must be recertified by submission of a new PAS at least ten (10) days, but no more than ninety (90) days, prior to the expiration of the current PAS. Failure to submit timely may result in a lapse in certification.

6.1 PAS QUALIFICATIONS AND RESPONSIBILITIES

The PAS must be completed by the OSDP Case Manager and Registered Nurse.

The responsibilities for completing the PAS are as follows:

- Conduct face to face interview with the applicant/client to the extent feasible, given the individual's physical and cognitive status;
- Obtain information from caregiver(s) and/or designated representative, to the extent practicable;
- Review medical records and other relevant medical documentation to verify medical conditions and services, to the extent practicable;
- Provide information to the applicant/client and their responsible party/designated representative about available Medicaid program placement options, to facilitate informed decision making;
- Provide information about alternative services/resources for individuals who may not be eligible for Medicaid long term care and
- Provide information about the secondary review process and appeal rights for individuals who may not be eligible for Medicaid long term care.

6.2 PAS DOCUMENTATION OF INFORMED CHOICE

When an individual is determined likely to require a home and community based waiver service, the individual or his or her legal representative will be:

- ❖ Informed of any feasible alternatives under the waiver; and
- ❖ Given the choice of either institutional or home and community based services.

The applicant/client, or legal representative, will initial their preference of placement on the Informed Choice section of the PAS Informed Choice form. The OSDP Case Manger must also sign an attestation that the applicant/client and/or the legal representative was informed of the identified DOM's long term care program options based on the results of the PAS and the applicant's/clients desired services. The Informed Choice document must be witnessed by a third party. The initial/signature page must be retained by the OSDP Case Manger for review by DOM, if requested.

(See Resource Guide for the PAS Informed Choice Form).

The consumer cannot receive services from:

- **More than one Medicaid Waiver program at a time, including waivers that are not administered by the Department of Rehabilitation Services such as the Elderly and Disabled Waiver and the Assisted Living Waiver.**
- **A Medicaid institutional program such as nursing facility or hospice.**

6.3 CONSUMER CHOICE AMONG SERVICES

Non – Waiver Services

The Case Management Team must document any available benefits and services the consumer is receiving before waiver funds are used to meet the individual's needs. Example: If the consumer is eligible for Medicare and needs medical supplies/equipment, services available through Medicare must be used before use of medical supplies/equipment provided through the waiver.

The OSDP Counselor is responsible for assisting the consumer in applying for and using all available non-waiver services.

The OSDP Counselor must consider all third party resources including services provided by family members and other informal supports to reduce waiver expenditures. Non-waiver services must be considered in the development of the Plan of Care (POC) and must not duplicate IL Waiver or TBI/SCI Waiver Services.

6.4 SIGNATURE ON FILE

Medicaid will follow Medicare policy and allow providers to obtain a lifetime authorization from the Medicaid applicant/client to submit Medicaid claims. This authorization must be signed at the time an application is taken. This authorization must be retained in the client's case file. Be sure the applicant/client signs his/her name. If the applicant/client cannot write his/her name, he/she should sign by a mark and a have a witness sign the applicant's/client's name and indicate by whom the name was entered. If the applicant/client is a minor or otherwise unable to sign, any responsible person such as a parent or guardian must enter the recipient's name and write "By," sign his/her own name and address in the space, show his/her relationship to the applicant/client and explain briefly why the applicant/client cannot sign.

See Resource Guide for Signature On File Form, (HCBS Resource Guide).

6.5 APPLICANTS WITHOUT MEDICAID ELIGIBILITY

If the applicant's individual income exceeds the Supplemental Security Income federal benefit rate (FBR) per month, the applicant can apply for Medicaid through the Special Handicapped Coverage Group, 300% of SSI federal benefit rate which is the institutional income limit for individuals entering a nursing facility. The special income level permits Medicaid to cover individuals who would be eligible for Medicaid as if they were in a nursing facility. The Special Income Criteria allows eligibility for persons with gross income at or below 300 percent of current SSI.

The special handicapped coverage group only applies to individuals who have been determined to meet the Medical eligibility criteria for the waiver by DOM.

The Special Income Criteria:

- ❖ Allows eligibility for persons with gross income at or below 300 percent of current SSI.

- ❖ Allows states to provide home and community based waiver services to children without regard to their parents' income or assets and to married individuals without regard to their spouse's income.

- ❖ Requires states to impose a post-eligibility cost-sharing burden.

- ❖ When the 300 percent rule is a state's only option for providing Medicaid to higher income persons, it allows persons to achieve eligibility by diverting excess income into a Miller trust.

6.5.1 APPLICANTS WITH MEDICAID ELIGIBILITY COVERAGE

At the time of the initial intake, information on the applicant's Medicaid and/or financial status will be obtained. OSDP staff handling the initial intake must determine if the applicant is currently on Medicaid and should check Envision to confirm the applicant's current status.

Applicant's who receive Supplemental Security Income (SSI) are already eligible for Medicaid and will not need to have a Medicaid eligibility decision.

It is the OSDP Counselor's responsibility to assist the individual in applying for Medicaid benefits.

6.6 APPLICATION PROCESS FOR MEDICAID ELIGIBILITY DETERMINATION

If the individual does not have Medicaid coverage, their case record will be reviewed by the Division of Medicaid to determine if they meet the medical criteria for the waiver. If approved, the Division of Medicaid will forward notification to the Medicaid regional office that the applicant has met medical certification for participation and would like to apply for coverage under the Home and Community based services Special Income Category (300% of SSI).

Division of Medicaid, Home and Community Based Services Division, will forward a cover letter to the OSDP Counselor stating that the individual's application for waiver services has been determined to meet the medical criteria for the waiver and will be certified pending approval for Medicaid coverage.

The IL Counselor will inform the individual in writing or by phone that he/she will need to go to their Medicaid Regional Office within 10 days to apply for Medicaid eligibility through the Special Handicapped Coverage Group.

The HCBS Division will maintain a case record in a pending status for 60 days from the date it was processed. If the applicant and/or their representative do not initiate appropriate action to obtain eligibility process, failure to comply will result in closure of their case.

After the applicant completes the application at the Regional Office, they have 45 days to provide all requested information to complete the eligibility process. Failure to comply will result in closure of their case.

Medicaid will inform the IL Counselor that he/she client has been approved.

Examples:

> Case record is approved 5/01/06, the applicant takes no action toward obtaining Medicaid eligibility by 07/01/06, case record will be disapproved and returned to the IL Counselor.
>
> Case record approved 5/01/06, applicant waits until 06/29/06 to fill out application at the Regional Office, the "clock" restarts time allow applicant 45 days to complete the eligibility process.

No services can be initiated under the waiver program until eligibility has been established. The Division of Medicaid will send a cover letter with a certification date to the IL Counselor.

6.7 FAMILY MEMBERS AND INFORMAL SUPPORTS

As part of the initial assessment, the Counselor determines the need for personal care services and the estimated hours necessary to meet those needs. The need for a particular task is determined based on the individual's functional impairment to complete that task and if that task will be completed by other sources including unpaid caregivers, such as family members or other informal supports. Personal Care Hours cannot be authorized if there is not a need for these services.

The Plan of Care (POC) should be developed considering the needs of the applicant and the stated intentions and willingness of the caregiver to provide unpaid care. The POC will reflect hours of those needed tasks that will not be provided by another source or the caregiver as unpaid care. The caregiver should be asked in all cases which services/tasks he will provide without payment.

Family members, except those legally responsible such as a spouse or parent of a minor, may be employed to be paid as Personal Care Attendants.

6.8 INFORMAL SUPPORT PROVIDING ASSISTANCE WITH ACTIVITIES OF DAILY LIVING

Activities of daily living necessary for daily functioning include eating, toileting, transfer, dressing, bathing and meal preparation as identified in Section II A of the Long Term Care/Pre Admission Screening (PAS) Instrument. The activities of daily living are those tasks that do impact the consumer's health and safety.

6.9 ENSURING HEALTH AND SAFETY

The OSDP Counselor and Nurse have the responsibility to ensure the consumer's health and safety and develop a Plan of Care (POC) that includes all necessary elements to adequately meet the consumer's needs. Use of informal supports, third party resources and other community resources are an integral part of the overall development of the POC. The use of third party resources ensures the most cost-effective and efficient use of funds to meet the individual's needs.

The Counselor must inform the family member or other non-paid supports of the importance of their contribution toward the Plan of Care.

6.10 INFORMING APPLICANTS/CLIENTS OF ESTATE RECOVERY

All individuals applying for the Independent Living Waiver or TBI/SCI Waiver services must be informed about Medicaid Estate Recovery. During the initial application process or quarterly home visits, the Counselor must inform the client about Estate Recovery and document the case file that this information was provided to them. At application, the fact that the client was informed of Estate Recovery can be documented in the Application Case note.

6.10.1 WHAT IS ESTATE RECOVERY?

In order for Estate Recovery to apply, the applicant/client must be eligible for Medicaid and be:

- age 55 and older, and,
- in a nursing facility or enrolled in a home and community based services waiver program at the time of death.
- enrolled in hospice at the time of death.

The Estate Recovery law does not apply if, at the time of death, the applicant/client has:

- A surviving husband or wife, or
- A surviving dependent child or children under 21 years of age, or
- A surviving dependent child or children of any age who are blind or disabled, or
- An undue hardship condition that causes Estate Recovery not to apply.

Estate property is made up of real and personal property that the applicant/client owns at the time of death:

- Real property such as home, family business, farm or ranch;
- Cash reserves, stocks, bonds, automobiles, recreational vehicles, mobile home;
- Or any property with value owned by the beneficiary in full or in part

6.11 PAS INSTRUMENT COMPONENTS

The PAS consist of ten (10) sections, most of which have two (2) or more subsections. The table below lists the sections/subsections and identifies the populations for whom each subsection applies.

Section/Subsection	Applies to:
I Intake	All Applicants
II Functional Screen	
IIA ADL's & IADL's	All Applicants
IIB Communication/Sensory	All Applicants
III Cognitive Screen	All applicants (caregiver response component applies only if caregiver is present)
IV Mood/Psychosocial & Behaviors	
IVA Mood/Psychosocial	All Applicants
IVB Behaviors	All Applicants
V Medical Screen	
VA Medical Conditions	All Applicants
VB Health-Related Services	All Applicants
VC Medications	All Applicants
VD Medical Stability	All Applicants
VE Medical Summary	All Applicants
VI Social Supports	
VI.1 Primary Caregiver	All applicants with a primary caregiver
VI.2 Formal Agency Supports	All Applicants
VII Home Environment	All applicants except Nursing Home and other institutional residents not seeking community placement
VIII Informed Choice	
VIII.1 Individual Strengths	All applicants except Nursing Home and other institutional residents not seeking community placement
VIII.2 Program Options & Desired Assistance	All Applicants
VIII.3 Individual Choice	All Applicants
IX Level II Determination (PASRR)	All applicants presented with Nursing Facility Placement as an option in Section VIII
X PAS Summary & Physician Certification	All Applicants

The PAS application may be reviewed in its entirety by logging on to: www.dom.state.ms.us, select Providers, select Envision. Enter your User ID and Password, select Provider, Long Term Care, PAS and Hardcopy PAS Application.

6.12 PAS CERTIFICATION PERIODS

Clinical eligibility will be granted for a period of one year. HCBS waiver clients desiring continued waiver services must be recertified by submission of a new PAS at least ten (10) days (but no more than ninety (90) days) prior to date of expiration of the current PAS. Failure to submit the PAS timely may result in a lapse of certification.

6.13 PRE-ADMISSION SCREENING (PAS) RE-CERTIFICATION

A re-assessment of an individual's functional limitations and functional capacities as they relate to activities of daily living and their impairment must be completed annually for individuals enrolled in the waiver. The re-certification re-assess' their need for services that will be developed on the Plan of Care to maintain them in his/her own home.

It is the responsibility of the OSDP Counselor and the Registered Nurse (Case Management Team) to complete the annual re-certification. It is performed in the home and again gives the case management team the opportunity to visually re-assess if the person continues to meet the medical criteria for the waiver program.

In order to assure that the POC is reassessed annually as required by the waiver requirements, the Counselor must:

1. Begin the re-certification process no sooner than 90 days prior to the certification end date/expiration of the current POC;
2. Complete the development of the re-certification POC and verify all aspects of eligibility and;
3. Complete all necessary procedures no sooner that 90 days prior to the expiration of the current POC and submit all information to OSDP Administration no later than 60 days prior to the expiration of the current POC.
4. Enter information in OSDP Program Browse page to reflect the date of reassessment and the date of the Physician's 260.

In addition to the above, the Counselor must run their tickler file from AACE which will ensure timely recertifications.

Note: The DOM-HCBS 301 Plan of Care must be completed at the same time as the re-certification assessment is completed. Counselors must again make sure that the individual understands that all services provided through the HCBS Waiver programs are subject to the approval of the Division of Medicaid.

7.0 FUNCTIONAL ASSESSMENT FOR ATTENDANT CARE SERVICES

If the client is requesting attendant care services through the State Attendant Care Program, a functional assessment must be completed. As part of the functional assessment, the Counselor determines the attendant care services the client needs and the estimated hours necessary to meet those needs. The need for the particular task is determined based on the client's functional impairment to complete the task and if that task will be completed by other sources including unpaid caregivers, such as family members or other informal supports. Attendant care hours should not be planned if there is not a need for these services. (See Resource Guide for the Functional Assessment Form).

The ILP should be developed and updated annually considering the needs of the client, stated intentions and willingness of the caregiver to provide unpaid care. Family members, except spouses and those legally responsible, may be employed as the attendant under the State Attendant Care Program.

Upon completion of the functional assessment, update the OSDP program browse page by entering the functional assessment date, start and end date and the number of PCA hours authorized.

The OSDP Counselor is required to make monthly contacts with clients receiving State Attendant Care with a face to face visit annually at the end of each state fiscal year.

The OSDP Counselor must make attempts to assist the client in accessing other resources for this service (i.e. Medicaid waiver programs) for those individuals requiring long term care.

Although the number of hours needed is determined during the functional assessment process, the number of hours an individual receives via the State Attendant Care Program may be affected by the availability of state funds. Any additional hours given above what has been approved must be approved by OSDP State Office Administration.

The functional assessment may be completed by the OSDP Counselor and does not require a Registered Nurse to be present.

7.1 FUNCTIONAL ASSESSMENT FOR TRANSITIONAL ATTENDANT CARE SERVICES

If the client is requesting transitional attendant care services through the TBI/SCI Trust Fund Program, a functional assessment must be completed. As part of the functional assessment, the Counselor determines the attendant care services the client needs and the estimated hours necessary to meet those needs. The need for the particular task is determined based on the client's functional impairment to complete the task and if that task will be completed by other sources including unpaid caregivers, such as family members or other informal supports. Transitional attendant care hours should not be planned if there is not a need for these services. (See Resource Guide for the Functional Assessment Form).

The ILP should be developed and updated annually considering the needs of the client, stated intentions and willingness of the caregiver to provide unpaid care. Family members, except spouses and those legally responsible, may be employed as the attendant under the TBI/SCI Trust Fund Program.

Upon completion of the functional assessment, update the OSDP program browse page by entering the functional assessment date, start and end date and the number of PCA hours authorized.

The OSDP Counselor is required to make monthly contacts with clients receiving transitional attendant care services.

The OSDP Counselor must make attempts to assist the client in accessing other resources for this service (i.e. Medicaid waiver programs) for those individuals requiring long term care.

There is a twelve-month time limit on transitional attendant care services. During this time, the client or family members will be assisted with seeking other attendant care options.

In addition to the functional assessment, the TBI/SCI Verification form must be completed by the treating physician. (See Resource Guide for TBI/SCI Verification form).

8.0 DETERMINING THE APPLICANT'S DISABILITY

Determining the client's disability is the first major step in the process. This process begins with the Counselor's recording of medical history obtained from the consumer during the application process. Information regarding their impairment, and illnesses including dates and types of treatments or services provided should be recorded. The names and addresses of physicians who have treated them, as well as, hospitals and clinics where they may have been a patient are important so that the Counselor may request, if needed, pertinent medical records. As much as possible, the Counselor should try to determine the client's primary care physician for the impairment they are reporting.

8.1 MEDICAL INFORMATION TO ESTABLISH ELIGIBILITY AND FOR THE PROVISION OF SERVICES

When an individual is in Application status, medical reports/examination, etc., are necessary to make a determination. When medical information is used as a basis to establish eligibility, the following guidelines shall be followed:

1. If a disability is reported and may be documented by medical Records but does not cause substantial functional limitations to activities of daily living or the condition is stable, this impairment does not have to be recorded on the Certificate of Eligibility. The Counselor's knowledge of this impairment and its stability, and the fact that it is not a factor to the rehabilitation process should be documented in Case notes or in the other section of the Certificate of Eligibility.

2. Medical information does not have to be signed if the diagnostician, medical groups, or clinic is clearly identified in the information. DDS reports, hospital/VA records data on letterhead stationery, faxes to Counselors, copies of letter to other physicians, and letters to Counselors are acceptable

3. Medical data not readily identifiable, handwritten notes, office/clinic notes, or pages from charts would all require a signature if the physician or office is not identified.

4. Patients name must be on all medical data to ensure that there is no question concerning the identification of the consumer/client.

5. Medical information, if used to help determine eligibility, must contain an actual diagnosis.

6. Medical documentation must be in the file and dated on or before the date of the certificate of eligibility.

7. Medical reports completed by a Family Nurse Practitioner (FNP) or Physicians Assistant must be co-signed by a physician to be acceptable.

8. Medical reports completed/signed by the physician's office staff (i.e. secretary, nurse, etc.) are never acceptable.

A disability will generally be considered stable if the answer is "no" to all the following questions:

1. Has the client's condition changed in the past year?

2. Has the client been hospitalized during the past year as a result of his/her condition?

3. Has the client's medication or therapy been changed in the past year?

8.2 MEDICAL CONSULTATION

Each MDRS District has a Medical Consultant that can be utilized by the OSDP staff. The medical consultants help Counselors interpret medical data and advise them regarding impairments.

It is important to remember that Counselors make all decisions regarding a client's eligibility for services.

Medical Consultation is required for the following situations:

- When there is conflicting medical information or recommendations for treatment.
- When multiple disabilities complicate the provision of services;
- To certify the acceptability of medical reports;
- To help interpret medical information received and provide information regarding the functional limitations that are not always clearly stated in medical reports.

8.3 DOCUMENTING ELIGIBILITY FOR SERVICES

At a minimum, the case file for each individual determined eligible for services must include the following information supporting the determination of eligibility:

- The medical, psychological, and other information supporting the presence of a most significant or significant physical or mental disability;

- The Certificate of Eligibility that records the impairment, justification analysis of a severe (serious) limitation in their ability in to function, continue functioning or move towards functioning independently in the family or community or to continue in employment.

The existence of a DISABILITY must be based upon medical, psychiatric, and/or psychological reports.

The IL Counselor may utilize other staff members (case reviews) and medical consultants in making eligibility decision. The final eligibility decision must be made and certified by the IL Counselor the case is assigned to.

8.4 ELIGIBILITY DETERMINATION EXTENSION

A determination of eligibility shall be made within 60 days from the date of application.

The 60 day period is considered to be consecutive calendar days and is counted in this manner. The 60 day period begins on the date the consumer or his/her representative signs the application for services.

A delay in determining eligibility for services may be extended if exceptional or unforeseen circumstances beyond the control of the Agency preclude making the eligibility determination within 60 days, and the Agency and the individual agree to a specified extension of time.

This agreement and extension must be documented as an eligibility determination extension. The extension must reflect the reason for the extension, the date in which the eligibility determination will be made, and that the individual agrees with the extension. Extensions cannot be more than 60 additional calendar days.

Under unusual circumstances, the Counselor Assistant can complete and sign the extension. The reason must be documented.

It is the sole responsibility of the Office of Special Disability Programs, Mississippi Department of Rehabilitation Services to determine if an individual is eligible for services and to determine the nature and scope of the services to be provided.

9.0 STATE ATTENDANT CARE ELIGIBILITY

The State Attendant Care Program is a special program created by the Mississippi Legislature in 1985 to provide personal care services to persons who have severe disabilities. The intent of the State Attendant Care Program is to provide a means for securing attendants for those not able to access personal care services under other programs.

Eligibility Criteria:

In order for an individual to be served under the State Attendant Care Program, the following eligibility criteria must be met:

- The presence of a significant mental or physical disability;
- The presence of a severe limitation in ability to function independently in the family or community, and
- A reasonable expectation that independent living rehabilitation services will significantly assist in their ability to function more independently in the home or community.

9.1 ELIGIBILITY CRITERIA FOR THE TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY TRUST FUND PROGRAM

In order for an individual to be served under the TBI/SCI Trust Fund program, the following eligibility criteria must be met:

1. Must have a certified traumatic brain or spinal cord injury. See Spinal Cord/Traumatic Brain Injury Verification Form. (Resource Guide)

    - Traumatic brain injury is defined as an insult to the skull, brain or its covering after birth, resulting from external trauma which produces an altered state of consciousness or anatomic motor, sensory, or cognitive/behavioral deficits. (This **excludes** any birth trauma.)

Note: Birth trauma is defined as a physical injury sustained by an infant during birth; and

Birth is defined as the entire separation of the infant from the maternal body (after cutting of the umbilical cord).

- Spinal cord injury is defined as a traumatic injury to the spinal cord or the cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two of the above three.

******This **excludes** brain injury and spinal cord injury **trauma** that results intentionally or unintentionally from medical intervention.

2. Must be certified as medically stable by the primary care physician. Medical stability is defined as the absence of the following:

    A. An active, life threatening condition (e.g. sepsis, respiratory, or other condition requiring systematic therapeutic measures);

    B. IV drip to control or support blood pressure;

    C. Intracranial pressure or arterial monitoring

10.0 INDEPENDENT LIVING WAIVER ELIGIBILITY

The Independent Living (IL) waiver provides services to clients who, but for the provision of such services, would require the level of care found in a nursing facility. The IL Waiver is a Medicaid home and community-based waiver operated jointly with the Division of Medicaid.

Eligibility is limited to individuals age sixteen (16) or older who have severe orthopedic and/or neurological impairments and possess maximum medical improvement potential. Maximum medical improvement potential, as defined by DOM, has been achieved when all of the following criteria are met:

- Client/applicant is able to communicate effectively with caregiver, Personal Care Attendants (PCA's, Counselors and others);

- Client/applicant is certified as medically stable by their primary physician. Medical stability is defined as the absence of the following:

    - an active, life threatening condition (e.g. sepsis, respiratory, or other condition requiring systematic therapeutic measures);

    - intravenous drip to control or support blood pressure;

    - inter-cranial pressure or arterial monitoring; and

    - a diagnosis of dementia, Alzheimer's, mental illness, mental retardation or any related condition of such severity that renders the individual unable to direct his/her own care.

Clinical eligibility for the IL waiver will be determined through the utilization of a comprehensive pre-admission screening tool which encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services.

Clients/applicants must be Medicaid eligible either as an SSI recipient or meet the 300% of the Supplemental Security Income Federal benefit rate.

Note: All services are provided pursuant to an individualized plan of care approved by the Division of Medicaid and the development of an Independent Living Plan.

Additional Eligibility for Enrollment:

The basic eligibility criteria include:

- age - be 16 years of age or older

Note: Elderly and Disabled Waiver serves individuals 21 years of age and older.

MR/DD Waiver services children under age 21.

- financial eligibility – the individual must be eligible for Medicaid as described in the waiver

- medical necessity – the individual must meet the level of care criteria for nursing facility (NF) care based on Physician Certification Form.

- waiver specific criteria the individual must meet based on his/her choice of services and service planning. They must:

- have a severe orthopedic and/or neurological impairment

- choose home and community based services in lieu of nursing facility care/informed choice;

- have an on-going need for waiver services;

- need assistance with one or more of the activities of daily living such as dressing, bathing, eating, toileting, transferring;

- be able to communicate effectively with caregivers, Personal Care Attendants, case managers, and others involved in their care, and

- be at risk of nursing facility placement if services were not available

Enrollment in the Independent Living Waiver is limited to:

- the number of individuals approved by the Centers for Medicare and Medicaid Services (CMS) or the availability of state funding

- individuals are enrolled from the Independent Living Waiver Referral List on a "first come, first served" basis

- MDRS suspends enrollment into the waiver program when it is determined that the existing caseloads exceed funds within the current budget year.

10.1 TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY WAIVER

The Traumatic Brain Injury (TBI)/Spinal Cord Injury (SCI) waiver provides services to clients who, but for the provision of such services, would require the level of care found in a nursing facility. The TBI/SCI Waiver is a Medicaid home and community-based waiver operated jointly with the Division of Medicaid.

Eligibility Criteria

1. Must have a certified traumatic brain or spinal cord injury. See Spinal Cord/Traumatic Brain Injury Verification Form. (Resource Guide)

    - Traumatic brain injury is defined as an insult to the skull, brain or its covering resulting from external trauma, which produces an altered state of consciousness or anatomic motor, sensory, or cognitive/behavioral deficit.

    - Spinal cord injury is defined as a traumatic injury to the spinal cord or the cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two of the above three.

2. Must be certified as medically stable by the primary care physician.

    Medical stability is defined as the absence of the following:

    A. An active, life threatening condition (e.g. sepsis, respiratory, or other condition requiring systematic therapeutic measures);

    B. IV drip to control or support blood pressure;

    C. Intracranial pressure or arterial monitoring

3. Be certified as meeting nursing home level of care by their primary care physician.

4. Be at risk of nursing home placement in the absence of waiver services;

5. Be able to communicate effectively with Personal Care Attendants, case managers (IL Counselor and Registered Nurse), and others involved in their care;

6. Meet the special income and assets limits (up to 300% of the Supplemental Security Income federal benefit rate) SSI.

Note: All services are provided pursuant to an individualized plan of care approved by the Division of Medicaid and the development of an Independent Living Plan.

Additional Eligibility for Enrollment

The basic eligibility criteria include:

- age - no age limit

- financial eligibility – the individual must be eligible for Medicaid as described in the waiver

- medical necessity – the individual must meet the level of care criteria for nursing facility (NF) care based on Physician Certification form

- waiver specific criteria the individual must meet based on his choice about services and service planning. He must:

- choose home and community based services in lieu of nursing facility care/informed choice;

- have a severe traumatic brain and/or spinal cord injury verified by a physician

- have an on-going need for waiver services;

- needs assistance with one or more of the activities of daily living such as dressing, bathing, eating, toileting, transferring;

- be able to supervise the Personal Care Attendant and direct/communicate their personal care needs

- be at risk of nursing facility placement if services were not available

Enrollment in the TBI/SCI Waiver is limited to:

- the number of individuals approved by the Centers for Medicare and Medicaid Services (CMS) or the availability of state funding

- individuals are enrolled from the Independent Living Waiver Referral List on a "first come, first served" basis

- MDRS suspends enrollment into the waiver program when it is determined that the existing case loads exceed funds within the current budget year.

10.2 THE TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY PHYSICIAN VERIFICATION FORM

The Traumatic Brain Injury/Spinal Cord Injury Physician Verification form must be completed by the physician certifying that the client's injury was due to trauma and that their condition is medically stable.

The original copy of the TBI/SCI Verification form should be kept in your file and a copy submitted to the DOM with the pre-admission screening application.

It is necessary to use the Verification form that is in the actual TBI/SCI Waiver.

(See Resource Guide for a copy of the TBI/SCI Verification form)

10.3 PRE-ADMISSION SCREENING APPEALS

Applicants/clients have the right to appeal long term care eligibility denials. If an individual files an appeal and the case has not already been subject to the secondary review process, it will be handled in the manner described in Section 10.4. If the secondary review has already occurred, the case will be reviewed again by a supervisory level clinician who has not previously reviewed the case. Appeals will be processed in accordance with existing state policies.

10.4 PAS SECONDARY CLINICAL REVIEWS

Secondary clinical reviews will be performed in the following circumstances:

- Individual scores below the clinical eligibility numerical threshold but falls into a DOM defined "automatic secondary review" range (score of 45-49)
- Individual is under the age of twelve (12) on the date of the screening
- Individual appeals the denial in accordance with Medicaid's appeal procedures

Secondary reviews will be performed by DOM Registered Nurses, Nurse Practitioners, Licensed Social Workers and/or physicians as deemed by DOM to be clinically appropriate. DOM reviewers may request additional supporting documentation from the OSDP Counselor before making a determination. The OSDP Counselor also may submit additional supporting documentation, in a format specified by DOM, for consideration during the secondary review.

In conducting the secondary review, the reviewer may consider all available information from the PAS as well as any additional documentation provided by the OSDP Counselor or applicant/client. The reviewer also may consult with the OSDP Counselor and/or the certifying physician.

Once the secondary review is completed DOM will notify the applicant/client and MDRS of its determination. If the secondary review upholds the finding of clinical ineligibility, the applicant/client retains the right to appeal.

10.5 PAS INITIAL CLINICAL ELIGIBILITY DETERMINATION

The completed PAS will be adjudicated through application of an eligibility algorithm that generates a numerical score. The numerical score will be compared to a DOM defined threshold score of fifty (50) or greater. If an individual's score is equal to or greater than the threshold of fifty (50), the applicant/client will be determined clinically eligible for Medicaid long term care.

Individuals seeking applicable HCBS waiver programs that meet the threshold of fifty (50) or greater, or approved based on a secondary review will be referred to the requested HCBS waiver program. Each request will be considered individually and the applicant/client shall be admitted to the waiver as soon as possible. DOM/LTC will submit the required documentation to Eligibility prior to admission as required for each HCBS waiver program. Financial eligibility requirements must be met at that time.

The Division of Medicaid will assign a hearing officer. The consumer/legal representative will be given advance notice of the hearing date, time, and place. The hearing may be conducted with all parties involved present, or it may be conducted as a conference call (telephone) hearing. The hearing will be recorded.

The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director of the Division of Medicaid. The Executive Director will make the final determination of the case, and the consumer/legal representative will receive written notification of the decision. The final administrative action including state or local will be made within ninety (90) days of the date of the initial request for a hearing. OSDP will be notified by the Division of Medicaid to either initiate/continue or terminate/reduce services.

During the appeals process, contested services that were already in place must remain in place unless the decision is one of immediate termination due to possible danger or racial or sexual harassment of the service providers. The OSDP Counselor/registered nurse is responsible for ensuring that the consumer receives all services that were in place prior to their receipt of the notice that informed them that an action will occur regarding services.

10.6 APPEAL AND HEARING PROCEDURES FOR THE IL AND TBI/SCI WAIVER

Decisions that result in services being denied, terminated, or reduced may be appealed. The consumer/legal representative has thirty (30) days from the date on the notice to appeal the decision. The consumer/legal representative can elect either a local or state hearing. **All appeals must be in writing.**

The consumer/legal representative is entitled to an initial appeal at the local level with the MDRS/OSDP Counselor and the immediate supervisor. The action will be explained at that time. The local hearing will be documented and become a permanent part of the consumer file.

If the consumer/legal representative does not agree with the decision made following the local hearing, he/she may appeal that decision by requesting a State level hearing within 15 days of the notice of the local hearing decision. The consumer/legal representative must submit this request in writing to the Division of Medicaid. Upon receiving the notification from the Division of Medicaid that the consumer has requested a State level hearing, the OSDP Counselor/District Manager assigned will prepare a copy of the pertinent case file documentation used to reach the decision and send the copy to OSDP in the State Office. The copy of the documentation must be forwarded to the Division of Medicaid no later than five (5) days after MDRS has been notified that the consumer has requested a State level hearing.

The Division of Medicaid will assign a hearing officer. The consumer/legal representative will be given advance notice of the hearing date, time, and place. The hearing may be conducted with all parties involved present, or it may be conducted as a conference call (telephone) hearing. The hearing will be recorded.

The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director of the Division of Medicaid. The Executive Director will make the final determination of the case, and the consumer/legal representative will receive written notification of the decision. The final administrative action including state or local will be made within ninety (90) days of the date of the initial request for a hearing. OSDP will be notified by the Division of Medicaid to either initiate/continue or terminate/reduce services.

During the appeals process, contested services that were already in place must remain in place unless the decision is one of immediate termination due to possible danger or racial or sexual harassment of the service providers. The OSDP Counselor/registered nurse is responsible for ensuring that the consumer receives all services that were in place prior to their receipt of the notice that informed them that an action will occur regarding services.

NOTE: *Refer to Resource Guide for appropriate notice of action forms.*

10.7 CONTINUATION OF SERVICES

(42 CFR 431.231)

If the consumer requests a hearing within 10 days of the date on the notice and prior to services being terminated, the services that the consumer is currently receiving may continue during the hearing process until a decision is made. Services must also continue if:

- Action is taken without giving the consumer advance notice of action when required;

- MDRS/OSDP determines that the action resulted from reasons not supported by Federal and State law or MDRS/DOM policy;

- If the consumer is unable to be located, services that were terminated must be reinstated if the consumer is located and requests that services be reinstated. *Reinstatement occurs only if they are still certified for the waiver (Same certification year).*

10.8 TERMINATION OF SERVICES IF THE PARTICIPANT DOES NOT APPEAL

If an individual does not request an appeal or request that services continue, IL or TBI/SCI Waiver services will end on the termination date that is on the notice they received.

If the certification ends before the 10-day notification period expires, the Counselor will continue services through the 10-day notification period.

11.0 INITIATION AND DEVELOPMENT OF THE PLAN

The ILP is essentially a plan of action but is also a statement of understanding regarding rights, responsibilities and certain procedures. (Secs.704(e) and 725 c (14) of the 1998 Rehabilitation Act Amendments; 34 CFR Sec. 364.52) (See Resource Guide for the Independent Living Plan (ILP) Form).

11.1 INITIATION & DEVELOPMENT OF THE INDEPENDENT LIVING PLAN (ILP)

A copy of the ILP and any amendments must be provided in an accessible format to the client and if he/she chooses, their guardian, parent, or other legally authorized advocate or representative.

When there is a concurrent program eligibility for the VR program, the ILP development and the provision of Independent Living Rehabilitation Services must be coordinated to the maximum extent possible with the IPE for VR services.

An ILP for a client with a disability receiving waiver services is developed in consideration of the client's Plan of Care and in accordance with the plan, policies, procedures and term of the interagency agreement.

The official copy of an ILP is the one that is signed by both the client and the Counselor. If the handwritten copy is official then it must contain all required information as well as signatures. If the handwritten copy is the official copy, the electronic ILP in AACE must mirror the handwritten copy. The electronic ILP does not have to be printed and placed in the case file if the handwritten copy is the official copy.

All OSDP/IL case files must contain a signed and agreed upon ILP. In some cases, there will be an ILP, Federal Required document, and a Plan of Care, Medicaid required form.

11.2 INDEPENDENT LIVING PLAN ANNUAL REVIEW

The ILP for Independent Living Service must be reviewed as often as necessary but at least on an annual basis to determine whether services are to be continued, revised, amended or discontinued or whether the client should be referred to VR or any other program. The annual review must consider all the original facts on which the ILP was developed, as well as, accumulated information and performance. The goal, objectives and services must be re-evaluated. The purpose of the review is to be certain the client is progressing in his/her program as originally planned. The client or his/her representative must be provided an opportunity to review the plan and if necessary, jointly agree to any needed revisions or amendments. (34 CFR Sec. 364.5 (c))

The ILP Annual Review must be dated and signed by the Counselor. The month the ILP was developed or the last amendment will be the anniversary date for the review. If the Counselor cannot meet with the client during this particular month, the Counselor must explain in Case notes why the annual review is delayed and a specific date must be scheduled to complete the review.

11.3 704 PREPARATION REPORT

Individual Consumers in Community – Based Living

RSA requires that we report the following information on each consumer we serve:

1. Did the services provided in the federal fiscal year help support the participant to successfully relocate from a nursing home or other institution to a community based living arrangement?

   Community – Based living arrangements include apartments, privately owned housing, self – directed assisted living, or self – directed with family/friends

2. Did the services provided in the federal fiscal year prevent the necessity of the participant entering a nursing home or other institution?

   Simply receiving attendant care services does not automatically equal being eligible for a nursing home or institution.

   These questions must be answered on each consumer once during the federal fiscal year, October 1- September 30. The RSA 704 Preparation Page can be accessed via the Plan Review Browse page.

11.4 ILP AMENDMENT

An ILP is initiated early in the rehabilitation process and is subject to continuous development and change. These changes, in some cases, should be implemented by an Amendment.

Amendments to the ILP are required when:

- there are substantial changes to the goal or objective.
- services need to be added.
- service end date is extended for more than one year.
- as with the ILP, all amendments must be agreed to and signed by the client, his/her representative and the IL Counselor.

11.5 ILP REVISION

A Plan Revision is required to make minor changes to already planned services.

Plan Revision is required to:

- ❖ extend the Plan End date less than a year.
- ❖ add a comparable benefit.
- ❖ extend a plan service for less than a year.

An ILP Revision shall be documented in Case notes. The Case note should be recorded as a plan revision.

11.6 ILP EDITING

A plan that has been agreed to and signed by the Client, his/her representative, cannot be edited to make an amendment or revision. This function should only be used to enter the Objective outcome and service end date.

12.0 HOME AND COMMUNITY BASED SERVICES – PLAN OF CARE (POC)

The Plan of Care, DOM-HCBS 301, is the fundamental tool by which the health and welfare of the individual served under the waiver is assured. It is the link between the assessment and the delivery of services.

The OSDP Counselor/Registered Nurse must, together with the potential consumer, develop a Plan of Care based upon assessment results.

The Plan of Care is developed at an in-person meeting with the individual/consumer by the OSDP Counselor and Registered Nurse. (See Resource Guide for the Plan of Care Form).

The individual's deficits identified on the PAS Application are addressed by the OSDP Counselor and Registered Nurse to develop a written plan of care. The Plan of Care is used to address those services and activities to overcome or ameliorate the effect of the deficits in accomplishing the activities of daily living and maintaining an independent lifestyle in the community.

The medical and physical limitations are considered simultaneously with the independent living potential of the individual to avoid institutionalization.

Applicable non- waivered services, services provided by other funding sources, are included in the Plan of Care and subsequently monitored as non-waivered services.

The need for any services on the Plan of Care must be addressed in one or more of the assessment areas. (Ex. Home Modification and Specialized Medical Supplies).

Note: There are no pre-determined or fixed limits on the number of services or the number of units of any particular service. (For example – personal care services).

The Plan of Care is subject to periodic reviews and updates. The purpose of these reviews is to determine the appropriateness and adequacy of the services provided and to ensure that the services furnished are consistent with the nature and severity of the individual's disability.

Plans of care must be submitted for the initial certification and annually for each re-certification. The Plan of Care must accompany the PAS Application with the Physician Summary Form. Added services must be approved by DOM. Sufficient documentation must be submitted to justify the added service request. See Resource Guide for detailed instructions on completing the 105 and added services request.

12.1 THE CASE MANAGEMENT TEAM AT THE SERVICE PLANNING MEETING

The OSDP Counselor leads the Case Management Team. Those included in the Case Management Team are the Counselor, client or his designated representative and the Registered Nurse.

The Case Management Team is involved and is responsible for planning through the assessment of the individual's needs during the development of the Plan of Care. The Case management Team is responsible for:

- Considering all available assessment information;
- Estimating the costs for the types and amounts of services identified as necessary to meet the consumer's needs;
- Determining that the consumer can be served safely in the community;
- Identifying the waiver and non-waiver services to be used to meet the consumers needs;
- Documenting the plan of care and other supporting documentation;
- Determining that the services identified on the POC developed are necessary as an alternative to institutional care and appropriate to meet the needs of the consumer

The Case Management Team must make all the determinations listed above for the initial and each subsequent POC.

If the OSDP Counselor/RN has doubts about the adequacy or appropriateness of the POC to meet the needs of the applicant in the community, these concerns should be expressed and documented during the assessment/re-assessment process.

The OSDP Counselor may involve other individuals such as the District Manager or other OSDP Administrative staff in the process.

Refusal of a consumer to sign the POC should be documented in the case file notes for the assessment meeting.

12.2 REVISING THE PLAN OF CARE (POC) – INCREASING /DECREASING SERVICES – REQUESTING APPROVAL

Within the certification year, it may be necessary to revise the POC due to changes in the needs of the client. The Counselor should request a service change in the POC, such as hours, days or SMS services, when there is significant improvement or decline in the client's condition and the POC does not reflect their current needs.

The OSDP Counselor must obtain appropriate documentation to support the need to change services. The request must be submitted for review and approval to their District Manager prior to any changes made to the POC.

The Counselor must:

- Review PCA Task Assignment Sheet and Timesheets to determine tasks the PCA is currently performing;
- Determine the reason(s) for the request to change services and review specific information from the client indicating that the client's condition requires a change in services;
  Example: *If the care was being provided as unpaid care by a family member, determine why this person is now unable to provide the care; OR determine if the client has had a significant change in their medical condition.*
- Obtain the client's consent to request current medical information, if additional documentation is needed, to support the change in their medical condition. Include this information, if obtained, prior to submitting the request for approval;
- Submit all supporting documentation, case notes, and a copy of the POC for review and approval to the District Manager. *NOTE: The District Manager, at their discretion, has the option of submitting the request to the OSDP Administrative RN for additional review of medical documentation.*

Once the District Manager has reviewed the request, determined if funds are available, he/she will notify the counselor in writing of the approval/disapproval;

If the disapproval is based on documentation submitted, a request will be made to the Counselor to submit or clarify documentation prior to final decision.

If the request has been approved, the District Manager will instruct the Counselor to amend the "electronic POC" and the "handwritten POC" to reflect the change(s) in services. (See Resource Guide for detailed instructions for submission to DOM.) The Counselor will save the amended electronic POC and then submit this to the POC/105 database.

A message form is not needed for this particular process. This means that DOM's approval is not needed when amending hours on the POC.

The approved increase in hours on the client's timesheets and the amended date on the electronic POC should be one and the same.

Therefore, the PCA cannot work the additional hours until the above procedure has been completed.

When the electronic POC is amended, the ILP in AACE must be amended immediately to reflect the change.

Counselor will send a MDRS Notice of Action to the client informing he/she of the changes in services.

12.3 REVISING THE PLAN OF CARE (POC) – ADDING NEW SERVICES - REQUESTING APPROVAL

The Counselor may request approval for added service(s) that were not included on the Plan of Care after it has been determined that the client has an unmet need for these items. **The request must be submitted for review and approval to their District Manager prior to any changes being made to the POC.** When an added service is requested, the Counselor must proceed with the following steps:

- Evaluate the necessity of the added service and obtain appropriate documentation to support the request for additional services to the POC;

- Obtain a doctor's prescription for the service item needed;

- Obtain two quotes for each added service item in order to compare costs;

- Investigate all comparable benefits (Medicaid, Medicare, Home Health, any other third party resource);

- Complete and submit the following to your District Manager for approval and review of documentation to verify appropriate need for additional service item(s).

    - ❖ Plan of Care
    - ❖ Case Note documentation
    - ❖ Approved Adaptive Aid Form
    - ❖ Copy of the Prescription(s)
    - ❖ Copy of Quotes
    - ❖ AT Specification Report if applicable

The District Manger will indicate his or her approval by signing the Adaptive Aid Form and returning it to the Counselor. *If there are questions regarding the documentation, a request will be made to the Counselor to submit or clarify documentation prior to final decision.*

- A copy of the Plan of Care must remain in the file until the original is received back from DOM indicating approval/disapproval of the added service.

- When the information is received by OSDP state office, the Administrative RN will review information for completeness and approval by the District Manager. Once the request has been reviewed and approved, the counselor will then forward the service request to DOM once the request has been processed by the OSDP State Office. (See Resource Guide for detailed instructions for submission to State office and DOM).

- After approval is received from DOM, OSDP state office will notify the counselor and District Manager via a Notice of Determination that the service has been approved.

- Funds will then be distributed to the Counselor via the Manager to plan and authorize for the added service.

12.4 TIME FRAME FOR AUTHORIZING FOR APPROVED MEDICAL SUPPLIES/EQUIPMENT

Within five (5) working days of receiving approval to purchase services, the services must be planned on the ILP, authorized and purchased. If supplies/equipment cannot be authorized due to unusual circumstances such as special supply needs or the availability of a supply, the client must be notified and given the reason. Case notes must be documented to reflect the delay in services.

12.5 RE-AUTHORIZING SUPPLIES CURRENTLY PLANNED AND APPROVED ON POC

If the client has existing supplies when it is time to re-authorize for the supplies, the Counselor must document that the client has existing supplies on hand, and they do not require delivery at this time. The vendor must be contacted so that they will not deliver surplus supplies.

Stock piling of medical supplies should not occur. Supplies needed on an on-going basis should be delivered so that there is not more than the one month supply in the client's home at a time. The delivery date of the supplies must be documented.

12.6 EMERGENCY SERVICE CHANGES TO THE PLAN OF CARE

If the client experiences an emergency or crisis that the OSDP Counselor/Registered Nurse in their judgment feels requires additional PCA hours, the Counselor must provide the care to meet the consumer's needs. The Counselor must then verbally notify the District Manager by the next work day of the change. The Counselor must then, within (7) seven work days, submit to OSDP Program Administration via the District Manager:

- The Case note or rationale for the service change or any other reports/documentation, the service and amount of additional services needed; the anticipated begin and end date for the service, signed by the OSDP Counselor;
- Documentation of medical necessity/prescription, AT evaluation, Adaptive Aid, Medical Supply form;
- A copy of the POC identifying the change

The OSDP Counselor may procure adaptive aids and medical supplies not currently authorized on the POC in emergencies that are defined as only situations that place the consumer's health and/or safety at risk. If procuring emergency adaptive aids and medical supplies, the Counselor must:

- Submit a copy of the POC identifying the change and the consumer's signature indicating that the change was an emergency;
- Verbally inform the Regional Manager by the next work day after purchasing the necessary item;
- Submit the following documentation to OSDP Administration via the Regional Manager:

  - the revised POC showing the change and the consumer's signature showing that the purchase was needed;
  - Case note/rationale explaining why the emergency purchase was necessary; and
  - Physician prescription or medical necessity indicating that the supply is an emergency

12.7 HOME AND COMMUNITY BASED SERVICES RECIPIENT ADMIT AND DISCHARGE FORM (105)

The Admit and Discharge form, HCBS 105, is used to admit and discharge individuals into and from the Home and Community Based Services waiver program. It is to be completed by the OSDP Counselor at the time of the initial certification into the program, at each re-certification and anytime there is a change in the individual's status.

See Resource Guide for the 105 form and detailed instructions on completing the form.

13.0 GENERAL

Assistive Technology (AT) is defined as the application of technology to alleviate barriers that interfere with the lives of individuals with disabilities and is intended to help the individual maintain or enhance his or her ability to function personally, socially, and/or vocationally.

MDRS Rehabilitation Engineers and Rehabilitation Technologists are available to provide consultation on all AT referrals as well as perform initial evaluations and assessments, and set-up AT equipment, provide follow-up evaluations, design and fabricate original items, and provide specifications and final inspections for AT services. When necessary, referrals will be made to outside sources. **Some AT services are provided by the Counselor without assistance from the AT program.**

Definitions:

Agriculture Accommodation – This service refers to those services provided for MDRS clients that would like to be able to work or to continue to work in the agriculture field that also includes turf, forestry, logging, row crop production, timber processing, and custom machinery and lawn care services, and anyone working in a support industry such as processing facility, machinery dealership, farm supply business, pest management business, agricultural consulting services, etc.

Auditory Accommodation – This service assists with the enhancement of communication through AT in the environment and relationships of a person who is hearing impaired.

Augmentative/Alternative Communication – This service refers to the provision of a device to supplement or to replace natural speech and/or writing.

Computer Access – This service refers to the provision of computer hardware and/or software.

Durable Medical Equipment (**Activities of Daily Living Devices) –** This service refers to devices that help a client perform daily living activities.

Environmental Control Unit – This service refers to the provision of a specific kind of assistive technology that gives a client control over items in their environment.

Home Modification – This service refers to modifications to a client's home.

Job Site Accommodation – This service refers to the process of modifying or rearranging job tasks (parts of a job) to allow a person with a disability to continue to work.

Seating and Mobility – This service refers to devices that assist a client with personal mobility such as a wheelchair, scooter, or wheelchair seating components.

Vehicle Accommodation – Vehicle Accommodations are broken into four specific services to assist a client with driving a vehicle:

> Driver Evaluation – This service refers to determining whether a client is able to safely drive a vehicle.
>
> Vehicle Consultation – This service refers to recommendations as to what type of vehicle would meet the client's needs. This service would be provided for clients who do not currently own a vehicle.
>
> Vehicle Assessment – This service refers to determining if a client's vehicle meets the MDRS policy for modifications and determining what modifications a client would need for a vehicle that they currently own.

Vision Aids (Non-Computer Related) – This service refers to the provision of devices used by an individual who is blind or has low vision that does not include a computer.

The Counselor should evaluate the client's need for AT services throughout the rehabilitation process. Examples of MDRS cases which may benefit from AT services include persons with mobility impairments, spinal cord injuries, traumatic brain injuries, visual impairments, speech impairments, respiratory impairments, cardiac impairments, learning disabilities, hearing impairments, and other limitations which result in severe disability. A determination of the need for AT should be an integral part of all rehabilitation services including the application process, evaluation process, trial work period, plan development, provision of services, placement, and follow-up services.

13.1 REFERRALS FOR AT SERVICES

VR/VRB, OSDP and ILB field staff will refer their clients to the Assistive Technology program by creating a Service Authorization in AACE.

> **NOTE: It is imperative that the Counselor verify that the information in the referral is accurate and up to date**

The referral will be assigned to the appropriate AT professional. The Counselor will be advised via **e-mail** the name of his/her contact. Complete medical packets should be forwarded (mailed/ecopied/faxed) to the appropriate professional handling the case.

The following information **must be included in the referral packet**:

a) Medical reports, as indicated by the client's disability(ies).
b) Specialist Reports, as appropriate to the individual's disability(ies) for the services being requested (i.e., psychological evaluation, educational diagnostic testing, orthopedic reports, ophthalmology reports, occupational therapy reports, physical therapy reports, and pertinent reports from rehabilitation centers)
c) An in depth description of the client's limitations and how they impact him/her.

Once the Service Authorization and medical packet have been reviewed by the AT professional, he/she will notify the client and the referring Counselor of the date and time of the initial evaluation. **Prior to any vendor accompanying an AT professional or Counselor during an evaluation for Durable Medical Equipment, the Counselor must identify the client's vendor of choice. Additionally, having vendors present during an evaluation should be limited and only with approval of the District Manager.** The Counselor is encouraged to maintain contact with the client and notify the AT professional of any changes in the client's status or condition. After performing an initial evaluation for the requested AT service, the AT professional will send a report with all recommendations and cost estimates to the Counselor. The Counselor will request, in writing, the specifications, drawings, and/or other information necessary for the provision of the AT service.

NOTE: AT recommendations are valid for one year from date of evaluation, with the exception of computer access evaluations which are valid for six months. If action is taken on a report that is over this limit, the AT program should be consulted to determine if any changes should be made to the recommendation. Also, should there be any significant changes in the client's physical and/or cognitive abilities, the AT program should be consulted to determine if any changes should be made to the original recommendation.

13.2 PURCHASING ASSISTIVE TECHNOLOGY SERVICES/DEVICES

It is necessary to follow the Mississippi Public Purchasing Law when purchasing items not covered by contract or comparable benefits. All items covered by any State contract must be authorized according to the State contract price (quotes/bids are not required).

For additional criteria for customized services, please see specific sections relating to:

- Computer Purchases – refer to Section 13.4.1
- Vehicle Accommodations – refer to Section 13.8

Purchases of $5,000 or under:

Purchases of $5,000 or under (exclusive of freight and/or shipping charges) do not require quotes or additional supervisory approval. These items should be purchased from the client's chosen vendor. To be an eligible DME vendor, the vendor must give MDRS a minimum discount of 20% off MSRP. (For Computer purchases, refer to Section 13.4.1

Purchases over $5,000 but not over $25,000:

Purchases over $5,000 but not in excess of $25,000 (exclusive of freight and/or shipping charges) require at least two written quotes or certification that the vendor is a single source. (Single source means that no comparative or competitive quotations can be obtained and no other item would be suitable or acceptable to meet the need; consequently, very rarely will there ever be a single source.)

Once the Counselor receives the AT recommendation, (except for items covered by contract or comparable benefits) he/she should give the client the choice of eligible vendors from which to receive the AT services(s)/device(s). The Counselor will solicit quotes from at least two of these chosen vendors. Each quote must discount the MSRP by a minimum of 20% to be considered. **NOTE: This does not include Home Modifications, Computers, or Vehicle Modifications.**

After the quotes have been obtained, they (or if the vendor is verified as a single source, send the single source verification) must be sent to the District Manager for approval if the amount is over $15,000. After approval by the District Manager, an authorization may be issued.

Purchases Over $25,000:

For purchases over $25,000 (exclusive of freight and/or shipping charges) the

Counselor must send the specifications for the items to the District Manager for approval. Once approved, the District Manager will then forward the material to the finance office. The finance office will arrange for advertising in the newspaper and provide guidance in obtaining bids. Purchases over $25,000 require approval by the District Manager. Furthermore, purchases over $45,000 require approval by the District Manager and the Director of Client/Field Services. If the lowest bid price is not selected, a justification must be written stating why the lowest bid price was not chosen.

NOTE: For Computer Based Equipment, you must refer to Section 13.4.1 For Vehicle Accommodations, you must refer to Section 13.8

Third Party Liability:

In the event the client has Medicare, Medicaid, or private insurance, the Counselor **must** verify the benefits available to the client before authorizing to the client-chosen vendor. If the client has Medicare, the client-chosen vendor must be willing to accept assignment of the Medicare benefits/payment. The vendor shall not require the client to sign any forms obligating the client or MDRS for amounts over and above the Medicare approved rate.

13.3 MAINTENANCE AND REPAIR COSTS

An AT professional will assist the client in securing satisfactory adjustments when problems occur that are under warranty or are reasonably expected to be remedied by a vendor at no cost to MDRS. **It is the client's responsibility to provide ongoing upkeep and maintenance cost. The Agency is not responsible for upkeep, repairs, or replacement of vehicle modifications, wheelchairs/scooters, computers, or other AT equipment.**

13.4 CUSTOMIZED SERVICES:

13.4.1 COMPUTER BASED AT EQUIPMENT/COMPUTER ACCESS

The area of computer access is very broad and encompasses any accommodations related to computer hardware or software that a client may need to accomplish his/her goal. It is imperative that the client and the Counselor have a clearly defined goal, and this goal should be noted in the service authorization.

Computer Literacy

A client must possess basic computer literacy to be eligible for an AT evaluation. The Assistive Technology program within MDRS does not provide computer literacy training for MDRS clients. Basic computer literacy can be obtained through community colleges, the Addie McBryde Center, the REACH Center, or other sources outside of MDRS. In addition, the AT program can only provide limited training (approximately four hours) on computer technology that is purchased for a client. If the AT professional determines that a client needs additional training, that information will be included in the AT report.

Purchasing Computer Based AT Equipment

The need for computer equipment and related software should be carefully evaluated by an AT professional prior to preparation of equipment specifications to be certain of equipment compatibility. Companion equipment/software should be thoroughly tested to make this determination.

After securing the recommendation for computer systems from the AT professional, Counselors should send a copy of the recommendation to the District Manager for approval. Once the District Manager approves the request, the Counselor should send the recommendation to Management Information Systems (MIS). MIS staff will obtain a list of approved vendors and price quotes and send it to the Counselor. **The IPE/ILP containing this equipment should not be written until this information is returned to the Counselor.** The Counselor should secure the signature of the client on the MDRS-AT-02 before the authorization is issued. A signed copy should be given to the client and the original must be retained in the case file.

The Counselor should request the vendor to ship the computer equipment to the AT professional handling the case. The Counselor should send a copy of the authorization to the AT professional and Management Information Systems (MIS). When delivering the computer or computer systems to the client, the AT professional shall secure the signature of the client on the MDRS-AT-03. A signed copy should be given to the client and the original must be retained in the case file.

Computer Repair

MDRS does not provide routine maintenance or computer repair. Referrals for AT service should not be made for routine maintenance or repair. The client should contact a local computer service or the manufacturer directly.

13.5 HOME MODIFICATION

Home Modification is the application of assistive technology to the residence of a client to remove barriers that prevent the client from reaching his/her specified goal. The desired goal(s) should be clearly stated on the referral for AT evaluation. The desired goal should be consistent with the client's overall goal (vocational/independence).

MDRS will not provide home modifications to a residence that is structurally unsound or in such disrepair that to forego said repairs prior to providing the modification would compromise the safety and effectiveness of the modification.

TITLE TO PROPERTY

Prior to referring an individual to the AT program for a home modification evaluation, the Counselor must determine property ownership of the residence to be modified. Rental or mortgaged property and/or property owned by someone other than the client **may** be considered for modification by MDRS for non-permanent modifications that can be moved to another location should the client move. It is necessary to secure written permission from the titleholder prior to modifying any property. This includes property:

I. Owned by other parties

II. Mortgaged

III. Rented

IV. Otherwise encumbered that could impede client's use

V. Owned by the client or the client and others

NOTE: Counselors should make a determination that the cost of any home modification is commensurate with the value of the home.

Home Additions

At no time will MDRS pay for modifications that add to the total square footage of the home. Total square footage refers to that area that is originally heated and cooled. MDRS may, however, pay for accessibility modifications to home additions that have been paid for by the client that are a component part of the original roofline.

MDRS does not participate in the construction of new homes other than in an advisory capacity.

Home Repair/Maintenance

MDRS does not pay for home repairs or general maintenance of homes.

Changes to Specifications

If it is necessary to make changes to the specifications, these changes must be made in writing with the approval of the AT professional who formulated the specifications. The AT professional, the client, the Counselor, and the contractor, must then sign these changes before they will be accepted. The Counselor is not responsible for payment of additions to the specifications unless this procedure has been followed. The Counselor should notify the client and the contractor that MDRS is not responsible for payment of additions to the specifications unless this procedure has been followed.

13.6 JOB SITE ACCOMMODATION

Job site accommodation is the process of modifying or rearranging job tasks (parts of a job) to allow a person with a disability to continue to work. Often a person with a disability can complete most of the job tasks required for a job, but there may be specific job tasks that the client cannot complete without modification due to the limitations imposed by the disability

The Service Authorization should identify the specific functional limitation that needs to be addressed. It is essential that the Counselor work with the employer to achieve the required services. Counselors are reminded of ADA and 504 responsibilities; however, the success of the client's rehabilitation takes precedence.

In House Job Site Accommodations – refer to the MDRS Policy Manual Chapter 1.02

13.7 SEATING AND MOBILITY

Evaluation of the client in his/her home or other appropriate setting will be conducted in order to evaluate the client for a proper seating and/or mobility system. The AT professional will determine if there are any physical deformities and/or limitations such as pelvic obliquities, scoliosis, contractures, fixations, etc. that need to be addressed by an occupational therapist or physical therapist.

NOTE: Medicare and some private insurance companies require seating and mobility systems to be evaluated/recommended by a licensed occupational or physical therapist.

The Counselor should secure the signature of the client on the MDRS-AT-02 before authorization is issued. A signed copy should be given to the client and the original must be retained in the case file. During the delivery of the seating and mobility system, the Agency AT professional should secure the signature of the client on the MDRS-AT-03. A signed copy should be given to the client and the original must be retained in the case file.

Repairs

MDRS does not provide routine maintenance or repair. Referrals for AT service should not be made for routine maintenance or repair. The client should contact a local vendor for repair service or the manufacturer directly**.**

13.8 VEHICLE ACCOMMODATION

Motor vehicle modifications may be provided, when necessary, to enable clients to prepare for, secure, retain, or regain employment or achieve independent living goals. Motor vehicle modification services can be provided when a specific employment goal has been identified on the IPE and subsequent rehabilitation services are required and will result in gainful employment or when identified as an approved/appropriate goal as part of an individuals ILP. **MDRS will not purchase or lease a vehicle.** Additionally, MDRS will only participate financially in the purchase of AT devices, adaptive equipment, and vehicle modifications.

Driver Evaluation

If a client will be driving a vehicle modified by MDRS, and MDRS will be providing adaptive driving equipment, that client must have a driving evaluation performed to determine if the client has acceptable physical and cognitive abilities to drive.

If the client has had a driving assessment in the last five years, an exception can be made. In order for the client to forego a driving assessment, the Counselor must have:

- a copy of the previous driving assessment, and
- a letter from the client's doctor stating there have been no changes in the last five years that would negatively affect this client's ability to drive a vehicle.

A copy of these documents should be included with the medical information sent with the AT referral.

NOTE: The client must hold a valid driver's license or permit to receive a driving assessment.

Vehicle Consultation

When a client is considering purchasing a new or used vehicle, it is beneficial for the client and MDRS if they are referred to AT prior to that purchase. The consultation will assist the client in acquiring a vehicle that meets their needs.

Vehicle Assessment

Vehicle Standards for Agency Approval

MDRS has established policies for the age and mileage of a vehicle that the agency can modify. The requirements are different depending on the type of modifications

the client will need. The age/mileage requirements are necessary because adaptive equipment is often expensive. Older vehicles are subject to more frequent malfunctions and have a shorter operating life than newer vehicles.

It is recognized that there are some vehicles that because of excellent care and condition may warrant consideration even though they exceed the age and mileage restriction and/or there may be hardship situations. So, even if the client's vehicle does not explicitly meet the above requirements, a referral can be made for vehicle modifications.

All vehicles must be in good working order. Used vehicles must have a vehicle inspection and mechanic's inspection in addition to meeting these requirements.

Modification Level	Vehicle Age / Mileage Requirements	
Level I	None	Mechanical gas/break (hand controls), unoccupied wheelchair/scooter loader/carrier, trailer hitch, steering devices, portable ramps, power and manual wheelchair tie-downs, simple non-driver devices, left foot accelerator, pedal extensions, secondary driving aids (non electrical), upgraded suspension.
Level II	< 7 years old or have < 140,000 miles	Occupied wheelchair/scooter lift, power transfer seat, manual transfer seat, automatic door openers, low and zero effort steering systems, low and zero effort breaking systems, power seat bases, electronic secondary controls.
Level III	< 3 years old or have < 60,000 miles	Modifications to the structure of the vehicle (raised doors, raised roof), power pan, electronic driving equipment, electronic secondary controls, lowered floor for a full size van.
Level IV	< 30,000 miles	Lowered floor minivan conversions.

NOTE: This listing is not exclusive. Any item that is not on this list should be approved by an AT professional to determine what level of modification that item would fall into.

Vehicle modifications are provided under state contract rates. The client will be informed of vendors who are under contract to provide modifications, repairs, and installation of adaptive equipment to vehicles. (See Vehicle Modification Fee Schedule)

MDRS will not provide vehicle modifications without proof of ownership and insurance coverage for both the vehicle and the installed equipment. The intended driver must possess a valid driver's license.

The client should sign the new Client/Owner Agreement of Understanding (MDRS- AT-02) form before the authorization is issued and the Assistive Technology Equipment Delivery Receipt (MDRS-At-03) form when the vehicle is delivered and before the statement of account is paid. Agency AT professionals are available for assistance with all aspects of this process.

The vehicle modifications will be inspected for quality assurance. For all vehicle modifications, the Counselor should notify the AT professional upon completion of the modifications so the AT professional can make arrangements for final inspection **before acceptance**. The AT professional should secure the signature of the client on the MDRS-AT-03. A signed copy should be given to the client and the original must be retained in the case file.

If a modified vehicle is sold, the client is responsible for seeing that the adaptive equipment is transferred to the replacement vehicle if practical. The Agency's AT professionals are available to assure that the transfer and refitting of the adaptive equipment is performed correctly and is deemed safe for normal operation.

Repairs and Maintenance

The Agency will neither repair nor replace motor vehicle modifications damaged by accident, vandalism, or fire.

The client should sign the new Client/Owner Agreement of Understanding (MDRS –AT-02) form before the authorization is issued and the Assistive Technology Equipment Delivery Receipt (MDRS-AT-03) form when the vehicle is delivered and before the statement of account is paid. Agency AT professionals are available for assistance with all aspects of this process.

The vehicle modifications will be inspected for quality assurance. For all vehicle modifications, the Counselor should notify the AT professional upon completion of the modifications so the AT professional can make arrangements for final inspection **before acceptance**. The AT professional should secure the signature of the client on the MDRS-AT-03. A signed copy should be given to the client and the original must be retained in the case file.

If a modified vehicle is sold, the client is responsible for seeing that the adaptive equipment is transferred to the replacement vehicle, if practical. The Agency’s AT professionals are available to assure that the transfer and refitting of the adaptive equipment is performed correctly and is deemed safe for normal operation.

13.9 PROJECT START (Success Through Assistive / Rehabilitative Technology)

Project **START** is made possible through a federal grant under the Technology-Related Assistance for Individuals with Disabilities Act of 1988 (P.L. 100-407), as amended in 1994 (continued funding made available by the Assistive Technology Act of 1998) to improve the awareness of and access to assistive technology. Project **START** is the State Assistive Technology Act program that works to improve the provision of assistive technology to individuals with disabilities of all ages through a comprehensive statewide program of technology-related assistance. Additionally, the program supports activities designed to maximize the ability of individuals with disabilities and their family members, guardians, and advocates to access and obtain assistive technology devices and services.

Project START'S Mission is:

Empowering Mississippians with disabilities through awareness, education, and access to Assistive Technology.

Key Activities of Project START

- Device Loan Program
- Device Reutilization
- Device Demonstration Program
- Training and Technical Assistance
- Public Awareness
- Coordination and Collaboration
- Transition Services

Without awareness and access to available assistive technology, Mississippians are unable to lead the productive, rewarding and independent lives that are possible with such assistance. Project START offers an on-line catalog that can be accessed at www.msprojectstart.org The on-line catalog covers a broad range of devices and equipment.

Device categories are listed below:

Adapted Toys for Children

Adaptive Computer Equipment

Augmentative & Alternative Communication (AAC)

Capability Switches

Communication

Computer

Durable Medical

Hearing Impairment

Low Vision

Mobility

Project START services are provided on a statewide basis and are available to individuals of all ages and disabilities as well as to service providers. Project START's activities are available at no cost to consumers in Mississippi. To access these services through MDRS, an AT referral in AACE is completed or the consumer can simply call Project START, or the consumer can fill out the request for services
on-line at www.msprojectstart.org

Device Loan Program

Project START's Device Loan Program (Try AT Before You Buy AT) enables people with disabilities to borrow and try out different types of AT devices for a limited time period (30 days for professional organizations and 90 days for consumers). Project START has developed an extensive device loan program containing state-of-the-art devices that cover a variety of needs. Equipment is used for demonstration, training, evaluation, and loan purposes. Equipment can be borrowed for the purpose of evaluation, for trial to determine its effectiveness and appropriateness, for use while a device is being repaired, or until a device is received from the manufacturer. The on-line catalog at www.msprojectstart.org contains all the available equipment for loan or to be given away at no charge to consumers. Project START continually upgrades and adds to its Device Loan Program to ensure appropriate devices are available.

Device Reutilization Program

START operates and/or supports device reuse through device exchange, repairing and recycling activities.

Device Exchange involves connecting an individual with a used device and an individual who needs a device. They often take the form of "want ads" or are similar to "e-bay" ads. In a device exchange, the current owner of the device and the prospective recipient of the device negotiate the terms of exchanging the device directly. For this service, consumers can access START Equipment Exchange Program at www.msprojectstart.org, click on the Equipment Exchange Link.

START recycling programs involve the intake of used devices (usually through donation) by consumers or different organizations in Mississippi. START is responsible for device storage and redistribution. It differs from refurbishment in that devices are generally redistributed "as is" or with only minor work such as cleaning. This program takes donations of all available assistive technology,

cleans it, and gives it away to Mississippians who can't afford and had no other access to the assistive technology.

Examples of donations are:

Walkers
Shower chairs
Manual wheelchairs
Hoyer lifts
CCTV
Low Vision Aids
FM Systems
Voice Amplification
Hospital Beds

Device Refurbishment: Computer and Mobility

START's Refurbishment program involves the intake and repair or customization of used devices for computers and mobility equipment. START is responsible for device storage, repair, and redistribution of computers and wheelchairs to consumers in Mississippi who can't afford or who have no other access to the assistive technology.

Device Demonstration

START provides consumers and others the opportunity to see the latest technology, get information, and learn what might be the most appropriate device for them through demonstrating all types of devices and equipment on a daily basis.

Training and Technical Assistance

Staff of Project START develops and disseminates training materials, conducts training, and provides technical assistance on numerous topics statewide including state and local educational agencies, other state and local agencies, early intervention programs, adult service programs, hospitals and other health care facilities, institutions of higher education, and businesses.

Public Awareness

The staff of Project START conducts public awareness activities including statewide information and referral systems designed to provide information that relates to the availability, benefits, appropriateness, and costs of AT. Project **START** provides, exhibits, and displays supplying information about assistive devices and services that relate to a cross-section of disabilities. Project **START** maintains a video and book library of assistive technology materials and information.

Consumers can request information and this request will be sent by mail within five working days of receiving the request or can be faxed or given over the phone when necessary.

Typical information provided by Project **START** includes the following:

- information concerning availability of assistive devices to meet specific needs;
- where and how to obtain evaluations for assistive devices;
- names of companies that manufacture the device;
- referral to assistive technology services providers;
- training opportunities for service providers, consumers, and other support groups.

Coordination and Collaboration

START works to improve access to assistive technology by partnering with many public and private entities responsible for policies, procedures, or funding for the provision of assistive technology devices and services to individuals with disabilities, service providers, and others.

Transition Services

START develops and disseminates training materials, conducts training, facilitates access to AT, and provides technical assistance to assist school children with disabilities transitioning to work or postsecondary education and adults with disabilities who are maintaining or transitioning to community living.

Information and Referral Services

Project START maintains a clearinghouse for assistive technology information which includes articles, newsletters, catalogs, and data from various manufacturers and retailers for assistive devices from numerous resources.

In addition, Project START has access to the Internet which allows the project to maintain the latest and most up-to-date information about assistive technology issues and devices from the national level.

Training

Project **START** sponsors conferences and monthly trainings with consumer groups and other service provider systems to increase awareness of and access to assistive technology on a comprehensive basis. Partnerships include but not limited to: T.K. Martin Center, Magnolia Speech School, Hudspeth Mental Health Center, TAD Center, Technology Learning Center and Jackson State University. Project **START** can arrange for consultants and experts to provide training in

areas such as the application of assistive technology in specific areas (i.e., special education, with specific disabilities, in specific environments, etc.), use of specific assistive devices, evaluation procedures for assistive technology, assistance in accessing various service provider systems in the State, information on funding options, and advocacy issues.

14.0 CASE FILE DOCUMENTATION OF MONITORING SERVICES

Documentation of monitoring activities, including, but not limited to:

- All Initial and Re-certification Plan of Care that include the services the consumer is receiving that are adequate to meet their needs
- Case notes/records in which the Counselor documents the appropriates and adequacy of the services;
- Monthly contacts should include Counselor evaluation of health and welfare of participants, correspondence received from Medicaid or SSI, contact attempted with participant/caregiver, and if a specific problem was identified, was a follow-up conducted or resolution obtained.
- Quarterly Reviews are assessed to see if they were done every three (3) months, was home environment assessed, satisfaction with services, appropriateness of services, plan of care updated with quarterly visit date and any updated information, verification of services provided including number of hours, or specific equipment, supplies, home adaptations requested per the participant.
- Documentation of any actions taken in a crisis; and
- Information regarding the consumer's complaints regarding services being provided.

If problems are identified, the OSDP Counselor is responsible for taking appropriate steps, including, but not limited to:

- Making a determination if the POC requires a change to address new needs
- Referring any suspected case of abuse or neglect to the Department of Human Services and the Attorney General's Office
- Referring any potential fraud to the Attorney General's Office
- Encouraging the consumer to comply with the POC in those situations in which the consumer is unwilling to allow the PCA or other providers to deliver services as identified in the POC or otherwise is refusing to comply with his/her POC;

14.1 REGISTERED NURSES/CASE MANAGERS

The registered nurse will accompany the Counselor.

A registered nurse must possess the following:

- a valid license to practice as a Registered Nurse in the State of Mississippi;
- be at least 18 years of age and
- complete the application for employment by Ability Works;

Proof of licensure can be validated by:

Checking the Mississippi Board of Nursing website at www.ms.gov/msbn.

- Go to the Nurse Inquiry link;
- Enter either the License Number and Last Name or
- Enter the last 4 digits of the SSN and the Last Name
- Print out the Nurse Details and keep it in your file

14.2 CASE MANAGEMENT ACTIVITIES THAT REQUIRE A REGISTERED NURSE:

- Initial assessment for IL and TBI/SCI Waiver
- Quarterly home visits and Personal Care Attendant certifications as deemed appropriate by the OSDP Counselor
- Assist Counselor in monitoring services delivered to consumers at quarterly home visits

15.0 PERSONAL CARE SERVICES/ATTENDANT CARE SERVICES

Personal Care Attendant Services are service components of the:

1. State Attendant Care Program/Fund;

2. Independent Living Waiver Program/Fund;

3. Traumatic Brain Injury/Spinal Cord Injury Trust Fund-12 month Transitional Programs;

4. Traumatic Brain Injury/Spinal Cord Injury Waiver (TBI/SCI) Program/Fund

Personal Care Attendant Services may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cueing so that a person performs those tasks by him/herself.

Such assistance most often relates to performance of ADLs (Activities of Daily Living) and Instrumental Activities of Daily Living (IADLs). ADLs are more frequently used than IADLs which include such services as meal preparation, household chores, laundry, money management, telephoning, shopping, and medication management. Personal Care Attendant Services promote self-sufficiency and independent living.

An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone cueing them along with supervision to ensure that the individual performs the task properly. This assistance can be provided under the TBI/SCI trust fund and TBI/SCI waiver Attendant Care Services.

Skilled services that may be performed only by a health professional, such as a nurse are not considered personal care services.

Personal care services are assistance with eating, bathing, dressing, personal hygiene, toileting, transferring, assisting with ambulation and other activities of daily living. PCA may include assistance with meal preparation for the individual. It may also include such housekeeping chores as laundry of the individual (rather than the individual's family) and other activities to prevent institutionalization for the person.

When provided under the TBI/SCI Trust Fund or TBI/SCI Waiver, Personal Care Attendants can also provide support for community participation by

accompanying and assisting the individual as necessary to access community resources; participate in community activities, including appointments, shopping, community recreation/leisure resources, and socialization opportunities.

Personal Care Service providers may be members of the individual's family. Payment will not be made for services furnished to an individual by any person legally responsible for the individual. These non-legally responsible relatives must meet the qualifications for Personal Care Attendants.

The spouse of an individual certified for the waiver is not eligible to be paid to provide services to his/her spouse (Legal responsible relative).

Parents/step parents of minor children are not eligible to be paid to provide services to their own children (Legal responsible relative).

A relative of an individual certified for the waiver may provide services and be certified as a PCA providing that:

- The relative does not have legal responsibility (the individual's spouse or the parent of a minor child);
- The relative is capable of providing the service and meets all standards to be certified. (Relatives of individuals are held to the same standards and are subject to the same expectations of quality service as are applied to any PCA).

(Services are often supplemented by informal, unpaid care provided by other family and friends. This practice is commendable and often necessary to reduce costs and assure quality and continuity of care).

*****The OSDP Counselor must explain to the relative that his/her status as a PCA may change his/her involvement in the individual's plan of care activities due to possible conflict of interest***.

15.1 CHOOSING A PERSONAL CARE ATTENDANT

The consumer's choice of attendants is not limited unless:

- The Counselor has specified that a particular attendant should not be employed; or
- The Counselor or RN has determined that the attendant is not providing adequate care

If an attendant is hired who has been identified as inappropriate or undesirable, they must meet with OSDP staff to discuss the issues and resolve the problem. If the problems occur regularly or cannot be resolved through discussion, the Counselor will document the discussion in AACE case notes and take appropriate action.

A current PCA should not continue unless:

- There is evidence to indicate that the PCA has abused, neglected, or exploited the consumer and others;
- The PCA has been providing inadequate care, and you have not been able to resolve the issue; or
- You discover that the PCA is the spouse or the individual legally responsible for the consumer.

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15.2 INDIVIDUAL REQUIREMENTS TO BE CONSIDERED FOR EMPLOYMENT/CERTIFICATION AS A PERSONAL CARE ATTENDANT (PCA)

1. Must be at least 18 years of age.

2. Must be a high school graduate, have a GED, or demonstrate the ability to read and write adequately to complete any required forms and reports of visits.

3. Must be able to follow verbal and written instructions.

4. Must have the ability to communicate effectively.

5. Must have no known physical/mental limitations that prevent lifting, transferring or providing any other assistance to the client.

6. If the individual reports any physical/mental limitations, appropriate documentation must be received from the individual's physician indicating they are able to perform the duties of a Personal Care Attendant.

7. All Personal Care Attendant providers must have completed training/ instruction that covers the purpose, functions, and tasks associated with the Personal Care Attendant program.

8. The Personal Care Attendant must also complete a supervised practical training period and be certified as competent by IL Counselor and Registered Nurse to perform each task of assistance with activities of daily living for the client for whom the services will be performed. No prescribed time limit is set for the practical training.

9. The PCA must demonstrate the ability to comprehend and comply with basic verbal and written instructions at a level determined by the IL Counselor and Registered Nurse to be adequate in fulfilling the responsibilities of the attendant.

10. An individual that has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or was continuously employed for twelve months as a nurse aide, orderly, nursing assistant or an equivalent position, shall be deemed to meet the classroom training requirements. The individual must provide the appropriate documentation to the IL Counselor, which

shall be filed in the client case file.

11. An individual that has satisfactorily provided attendant care services for four (4) weeks prior to coverage under the waiver program, with such service certified by the IL Counselor and Registered Nurse, shall be deemed to meet the training and competency requirements. The client's case file must contain the appropriate documentation.

12. A PCA may be certified by the Counselor and the Registered Nurse at the time of the initial assessment. However, the PCA cannot begin providing services to the client until the client has been given a certification date, and MDRS has received a Notice of Determination from the Division of Medicaid. If another funding source will be paying for the services, such as TBI/SCI Trust fund, the PCA can begin providing services.

13. Background checks will be performed on all PCA applicants. The background check will be processed through MS Bureau of Investigation and must be clear of any felony convictions or certain misdemeanors. A PCA cannot begin employment until the entire application has been processed by the state office.

14. Complete the Application for Employment with Ability Works of Jackson and the PCA must provide all employment verification documentation prior to their initial date of providing services to the client.

(See Resource Guide for instructions on how to certify a PCA)

15.3 CERTIFICATION IN WHICH A NEW PCA CERTIFICATION PROCESS MAY NOT BE REQUIRED

1. If a PCA has previously been certified to provide services for a particular client and their employment ended, but within twelve (12) months of the last day they were employed for the particular client, the client desires to employ that same person, they do not have to be re-certified unless the client's condition has changed since the last day that person worked for them. However, the Counselor must work with the client and PCA to complete a new Task Assignment Sheet so that there will be a clear understanding of the tasks the client is needing and requesting assistance with. The Counselor must also ensure the PCA understands how to complete the daily time log and understand the payroll process. The case file must document this. If it has been more than 12 months since the PCA was employed to work for a particular client, they must be re-certified.

2. If a PCA was certified to provide services for a particular client and another client wishes to employ them as their PCA, the PCA must be certified to work for each individual client. If the PCA has since completed some type of formal training (ex: Nurse Aide training program) since they were certified, a new Certification of Provider Minimum Standards must be completed. A copy of all PCA certification information must be in the client's case file that the PCA is providing services to.

3. If a PCA was certified to provide services for a particular client but is no longer working for the client, and a different client has requested to employ this particular PCA, even if within 12 months of the last day of employment as a PCA, they must be certified to work for the new client.

15.4 PERSONAL CARE ATTENDANT (PCA) TRAINING RESPONSIBILITIES OF THE REGISTERED NURSE AND THE OSDP COUNSELOR

Training shall be conducted by the client (or caregiver), the OSDP Counselor and Registered Nurse. Training shall also include disability awareness, employee employer relationships, and the need of respect for the client's privacy and property.

The Counselor must provide orientation regarding the Academic Requirements, and the RN/Counselor should provide orientation to the functional requirements for a PCA in the client's home, on or before the service initiation date for PCA Services, in order to:

- Provide them necessary training to deliver the personal care tasks and document that the orientation/training was provided or initiated;
- Determine if the individual is competent to deliver the authorized personal care tasks and document competency on the Provider Competency Form

The Counselor/RN will provide information to the PCA on the following:

- Information about the client's condition and how it may affect the performance of tasks;
- Tasks to be performed, work schedule, safety and procedures;
- Changes in the client's condition in which they should contact the Counselor to report the problem

If more than one attendant is needed to provide the service, the individuals identified as attendants should be certified at the same time.

The Counselor will provide information to the PCA on the following:

- The maximum number of PCA hours per day and the number of days per week the client is certified/approved to receive.
- Discuss with the PCA on how to complete the daily time logs.
- Inform the PCA of the pay periods and the amount to be paid.
- Inform the PCA that services cannot be rendered while the client is in the hospital.

The PCA will be instructed to provide information to the Counselor on the following:

- To provide at least 5 days notice if they decide to no longer work for the client.

- If the condition of the client changes (improves/clients condition declines).

15.5 FLEXIBILITY TO CHANGE PERSONAL CARE ASSISTANCE TASKS ASSIGNED

The consumer and the Counselor can modify the initial schedule and change the personal assistance tasks assigned that are included on the PCA Task Assignment Sheet to a mutually agreeable schedule that will meet the client's needs. This does not change the number of hours that have been approved as needed. Only PCA tasks that are allowed on the IL Waiver or TBI/SCI Waiver can be provided and PCA paid for. If additional hours are needed, the procedures outlined in 12.2 must be utilized. The schedule modification can be ongoing; for example, the client scheduled tub bathe daily can be changed to 4 times per week; or tasks assigned Monday, Wednesday and Friday can be changed to Monday, Tuesday and Wednesday. Flexibility allows the client tasks to meet the particular needs of the client considering changes in their condition and wants. Hours are based solely on hours assumed to be provided within the home environment. Flexibility is not intended to be for convenience or to be applied to justify the absence of an attendant or break in services.

OSDP has a backup system to assure the provision of all PCA services on the schedule agreed and approved without service break; even if there are unexpected changes in personnel.

If the client notifies the Counselor that the PCA has not provided services as mutually agreed, the Counselor must contact the PCA to find out the problem of which endangered the health and safety of the client.

15.6 APPROVING ATTENDANT'S TIMESHEET

The attendant is responsible for completing their timesheet and should be instructed to send in timesheets based on the designated payroll dates. The attendant should be cautioned about holding time logs for months prior to sending them for payment. Failure to submit time logs in a timely manner could result in non-payment.

The OSDP Counselor must review the attendant's timesheet to verify that the tasks assigned are being provided and the number of hours approved are not exceeded. The attendant will only be paid for the hours they are approved by MDRS to work.

16.0 DURABLE MEDICAL/SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized medical equipment and supplies are devices, controls, or appliances that enable individuals to increase their abilities to perform ADL's, or to perceive, control, or communicate with the environment in which they live. These services also include items necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan.

Specialized medical supplies are supplies that are medically necessary to meet the needs of the consumer. The Counselor must document the necessity of the requested medical supply based on:

- Consumer's disability or medical condition; and
- Evaluation of the medical supply to adequately support the consumer living in the most integrated setting possible in the community.
- Medical supplies are only covered after the consumer has exhausted any insurance, including Medicaid and Medicare, the consumer is eligible to receive.

Covered Medical supplies include:

- Briefs
- Blue pads
- Underpads
- Catheters
- Gloves
- Drainage Bags
- Leg Bags
- Skin Barrier Products (medically prescribed)
- Ostomy Supplies (medically prescribed)

16.1 SPECIALIZED MEDICAL EQUIPMENT AND ADAPTIVE AIDS

Specialized medical equipment/adaptive aids are devices, controls, or appliances that increase a consumer's ability to:

- Perform Activities of Daily Living;
- Perceive, control, or communicate with the environment in which they live;
- Ensure safety, security, and accessibility.

Medical equipment/adaptive aids may:

- Assist with mobility and communication;
- Compensate for conditions resulting in disability or loss of function.
- Medical equipment/adaptive aids are only covered after the consumer has exhausted any insurance, including Medicaid and Medicare, the consumer is eligible to receive.

16.2 MEDICAL EQUIPMENT/ADAPTIVE AIDS COVERED

Medical equipment/adaptive aids consist of the following services:

Lifts:
- Wheelchair lifts
- Porch lifts
- Hydraulic, manual, or other electronic lifts
- Bathtub seat lifts
- Transfer bench

Mobility Aids:
- Manual/electric wheelchairs and necessary accessories
- Scooters
- Braces, crutches, walkers, canes
- Prescribed prosthetic devices
- Prescribed orthotic devices, orthopedic shoes and other prescribed footwear
- Portable ramps and
- Batteries and chargers

Positioning Devices:
- Customized seating systems
- Electric or manual hospital beds, tilt-frame bed, and necessary accessories
- Trapeze bars
- Egg crate mattresses, sheepskin, and other medically related padding

Communication Aids (including repair, maintenance and batteries):
- Augmentative communication devices
- Speech amplifies, aids and assistive devices
- Hearing aids

Control Switches/Pneumatic Switches and Devices:
- Sip and puff controls and
- Adaptive switches/devices

Environmental Control Units:
- Locks
- Electronic devices
- Voice activated, light-activated, oral motion-activated devices

Adaptive equipment for activities of daily living:

- Assistive devices:
    - Reachers
    - Holders
    - Shower chairs
    - Overbed tray tables

- Medically Necessary Durable Medical Equipment not covered in the State plan for the Mississippi Medicaid Program

- Temporary rental of medically necessary durable medical equipment to allow for repair, purchase, replacement of essential equipment, or temporary usage of the equipment.

16.3 MAKING REQUESTS FOR NON-COVERED ITEMS

The request must include:

- A copy of the Rationale for Adaptive Aids, Medical Equipment
- The cost estimate/price quote
- Adaptive Aid Form indicating the item is not covered by Medicare, Medicaid or other private insurance and
- Assistive Technology Report (if applicable) and
- Medical Prescription (if applicable)

16.4 REQUESTING ITEMS THAT ARE NOT ON THE LIST OF COVERED MEDICAL EQUIPMENT/ADAPTIVE AIDS

The Counselor must submit a request to the District Manager for approval of an adaptive aid or medical equipment that is not on the current list. The Counselor must forward the request to the District Manager. The District Manager will staff the case with the Registered Nurse and Program Director based on:

- How the request is related to the consumer's disability, and

- If the Medical equipment is:

    - Medically necessary
    - Cost effective and
    - Necessary to prevent institutionalization

Federal Regulations and State Purchasing laws require a Fee Schedule be established for all purchases. However, some items do not have a fee listed in the fee schedule and must be manually priced.

16.5 UTILIZING COMPARABLE BENEFITS, THIRD PARTY PROVIDERS, BEFORE PURCHASING ADAPTIVE AID/MEDICAL EQUIPMENT

All comparable benefits/third party providers the consumer is eligible for must be accessed before using the waiver or any other funding program to pay for adaptive aids or medical equipment. The Counselor must work with the vendor to ensure that, if the consumer is eligible for Medicare, Medicaid, Home Health Services, or any other comparable benefit, the resources are used to meet the consumer's need for services. If the Counselor determines the consumer qualifies for services provided by another resource, they must obtain documentation to support their eligibility for the resource.

16.6 REQUESTING AN ADAPTIVE AID/MEDICAL EQUIPMENT THAT THE COUNSELOR THINKS MAY NOT BE PAID

The Counselor must submit a request with supporting documentation to the District Manager for a decision. It is outside of the Counselor's role to make decisions about the adaptive aids for which will or will not be covered. Decisions regarding such request must be made by the Counselor and must be made under OSDP procedures to ensure the consumer's due process rights are observed.

16.7 DOCUMENTATION REQUIRED JUSTIFYING COST-EFFECTIVE PURCHASE OF ADAPTIVE AID/MEDICAL EQUIPMENT:

A price quote from at a minimum of two (2) vendors is required to purchase medical equipment/adaptive aid.

The quote must contain:

- Name of the adaptive aid/medical equipment
- A price quote
- Date of the quote
- Name of agency

DME exempt from obtaining two (2) quotes are:

- Prosthesis
- Orthotics
- Wheelchairs and accessories
- Hospital Beds and accessories
- Motorized Scooters
- Patient Lifts and
- Other medically prescribed, medically necessary DME

Regardless of whether the vendor is also the manufacturer, or the vendor is purchasing from a manufacturer or from a distributor/supplier, it is the responsibility of the vendor to clearly note whether a charge is the MSRP or cost. Vendors are entirely responsible for submitting correct documentation for DME at MSRP or cost. Vendors should be able to produce documentation to show the charges can be substantiated if audited. The Counselor will provide information on vendors of specialized medical equipment and supplies so that the consumer can make and ***informed choice regarding vendor for services.***

Specialized medical equipment, supplies, and adaptive aids and any other Medically Prescribed DME items not elsewhere listed in the printed OVR Fee Schedule may be manually priced and purchased from any authorized Durable Medical Equipment dealer/vendor.

Quotes are not acceptable as an invoice.

16.8 DURABLE MEDICAL EQUIPMENT PRIOR TO TRANSITION

Recommended/Medically Prescribed Durable Medical Equipment can be purchased within 60 days of a scheduled transition date if the item is an approved waiver service.

16.9 SPECIALIZED MEDICAL SUPPLIES FEE SCHEDULE/COST NEUTRALITY

Specialized medical equipment and supplies include devices, controls or appliances that will enhance the client's ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes equipment and supplies necessary for life support, supplies and equipment necessary for the proper functioning of such items, and durable and nondurable medical equipment not available under the Medicaid State Plan. The need for/use of such items must be documented in the assessment/case file and approved on the plan of care.

Items reimbursed with waiver funds are in addition to medical equipment and supplies furnished under the Medicaid State Plan. Items not of direct medical or remedial benefit to the client are excluded.

Medicaid waiver funds are utilized as the payor of last resort. The Counselor must request payment from other sources (i.e., Medicare, private insurance, etc.) prior to submitting claims for reimbursement to the Division of Medicaid.

The maximum dollar amount of all approved services on the plan of care is limited to the latest CMS 372-372 Lag Report cost neutrality comparison threshold, i.e. annualized nursing home cost. In an attempt to ensure the client's plan of care does not exceed the annual nursing home cost, a list of medical supplies and a fee schedule is developed to indicate the maximum amount of supplies. See SMS Fee Schedule at end of section for a complete list of medical supplies and the maximum allowed by MDRS/OSDP.

Maximum Units

If a client is requesting supplies that exceed the maximum units, prior approval must be requested with accompanying documentation as to why the additional supplies are being requested.

A letter from the attending physician must be submitted to the District Manager to determine medical necessity. The letter must address the client's diagnosis, the effects of the condition, the period of time for which the approval is being requested and why the excessive number is medically necessary.

Catheters/Catheter Kits

- Intermittent Catheters are for urinary retention

- Foley Catheters are for urinary incontinence and retention

- Catheter Kits may be approved for a maximum of three months at a time. Chronic UTI's must be documented for intermittent kits to be covered.

Supply Name	Supply Code	Beginning Date	End Date	Maximum Units
Disposables				
Briefs, Diapers, Pullups: (all sizes)	Not Covered	04/01/2010	12/31/9999	200/month Or 2 boxes
Under Pads				
Blue Pads/disposal All sizes	Not covered	04/01/2010	12/31/9999	200/month Or 2 cases
Catheters				
Catheters: Condom External (all sizes)	A4349	04/01/2010	12/31/9999	35/month
Catheter, Intermittent	A4351	04/01/2010	12/31/9999	200/month
Collection device	A4327	04/01/2010	12/31/9999	2/month
Collection pouch	A4328	04/01/2010	12/31/9999	2/month
Catheter-Urethral Foley	A4352	04/01/2010	12/31/9999	200/month
Leg strap Foley	A4334	04/01/2010	12/31/9999	1/month
Catheter Kit closed system	A4353	04/01/2010	12/31/9999	200/quarterly
Urinary Drainage leg bag	A4357	04/01/2010	12/31/9999	1/month
➢ Vinyl	A4358	04/01/2010	12/31/9999	1/moth
➢ Latex	A5112	04/01/2010	12/31/9999	1/month
Urinary Bed bag		04/01/2010	12/31/9999	
Irrigation tubing set	A4355	04/01/2010	12/31/9999	3/month
Bedside Drainage Bottle	A5102	04/01/2010	12/31/9999	1 quarterly
Extension drainage tubing	A4331	04/01/2010	12/31/9999	5/month
Adhesive Catheter Anchoring Device	A4333	04/01/2010	12/31/9999	35/month
Gloves				
➢ Non Sterile	A4927	04/01/2010	12/31/9999	2 boxes/50 pairs
➢ Sterile	A4930	04/01/2010	12/31/9999	2 boxes/50 pairs
Skin Sealants				
Lantiseptic, Calmoseptine, Medisurge Cream	A6250	04/01/2010	12/31/9999	50 tubes
Gauze				
Non impregnated, sterile pad 4x4 w/o adhesive border	A6216 A6402, etc.	04/01/2010	12/31/9999	200/pads
Tubes				
Gastrostomy-Feeding Tubes, 14Fr-24Fr	B4087 B4088	04/01/2010	12/31/9999	1/month 1/month
Syringe				
Syringes, 60cc pole bag	A4213	04/01/2010	12/31/9999	120/month
Skin cleaners				

Alcohol prep pads	A4245	04/01/2010	12/31/9999	2 boxes/month
Irrigation Solutions				
KY Jelly Lubricant	A4332	04/01/2010	12/31/9999	35/month
Tape				
18 square inches Waterproof	A4450	04/01/2010	12/31/9999	2/month
18 square inches Non water proof	A4453	04/01/2010	12/31/9999	2/month

Ostomy Supplies

Ostomy Supplies can be requested if needed. The table below contains a few items on the list.

Supply name	**Supply Code Quantity**	**Beginning Date**	**End Date**	**MDRS Cost**
*Skin Barrier, solid	A4362	04/01/2010	12/31/9999	20/month
Adhesive liquid	A4364	04/01/2010	12/31/9999	4/month
Ostomy Belt	A4367	04/01/2010	12/31/9999	1/month
Ostomy Skin Barrier, liquid	A4369	04/01/2010	12/31/9999	1/month

17.0 RESPITE CARE SERVICES

Respite Care Services are a service component of the TBI/SCI Trust fund and the TBI/SCI Waiver. Respite care services gives short-term, temporary relief to the usual caregiver because of the absence or need for relief of the caregiver. Respite provides all the necessary care that the usual caregiver would provide during that time period to the client. Respite care enables the client to remain in their current living situations and provides services to the family member. Respite care services and PCA services are not the same.

Goals of Respite:

- ❖ Reduce stress and help maintain family relations
- ❖ Assist and strengthen the family as a unit
- ❖ Contribute to good physical and emotional health
- ❖ Provide the caregiver time to rest, relax, and re-create

Respite care may be provided in the individual's home or place of residence, Foster Home or Institution – Medicaid certified Hospital, Medicaid certified Nursing Facility, Group Home and Licensed respite care facility.

An in-home companion, Nurse Aide/Assistant, Licensed Practical Nurse or Registered Nurse, may provide respite care services. The primary care physician determines the level of respite care that the client requires. This is documented by his/her physician by completion of the Respite Tier-Determination Form. (See Resource Guide)

Tier 1 – Companion - $7.25

Tier 2 – Nurse Aide - $9.00

Tier 3 – Licensed Practical Nurse - $12.00

Tier 4 – Registered Nurse - $18.00

All respite care providers must be certified as meeting the skill level determined to be required by the physician, by the OSDP Counselor and the Registered Nurse (Case Management).

When respite care is provided, payment for other duplicative services is precluded.

The Tier determination level should also be reflected on the authorization for services so that the appropriate pay level (Tier) is verified.

Limitation: An individual is allowed a maximum of 288 respite hours per year which is scheduled at the discretion of the individual and regular caregiver. However, the OSDP Counselor must be notified when it becomes necessary for the individual to use respite services that have been planned on the Plan of Care for waiver cases and ILP for all IL cases.

17.1 CERTIFICATIONS REQUIRED FOR RESPITE PROVIDERS

1. In Home Companion

- Must be at least 18 years of age.

- Must be a high school graduate, have GED, and/or demonstrate ability to read and write adequately to complete required forms and reports of visits and follow verbal and written instructors.

- Must have no known physical/mental limitations that interfere with their ability to lift, transfer or provide any other assistance to the client. If the individual indicates any physical/mental limitations, statement must be received form their primary care physician treating that condition indicating their ability to perform the duties of a respite provider.

- Must demonstrate their ability to perform each task of assistance with the activities of daily living to the recipient, IL Counselor and Registered Nurse prior to rendering any services under the waiver.

- An individual that has satisfactorily provided in-home companion respite services for four (4) weeks prior to coverage under the waiver program, with such service certified by and verified by the client, the IL Counselor and the Registered Nurse.

2. Certified Nurse Assistant/Aide

- Must be at least 18 years of age.

- Must have satisfactorily completed a nurse aide training program for a hospital, nursing facility or in home health agency (Copy of Certification) or

- Was continuously employed for twelve months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities.

- Must have no known physical/mental limitations that interfere with their ability to lift, transfer or provide any other assistance to the client. If the individual indicates any physical/mental limitations, statement must be received from their primary care physician treating that -

condition indicating their ability to perform the duties of a respite provider.

3. LPN- Licensed Practical Nurse

- ❖ Must be at least 18 years of age.
- ❖ Must have satisfactorily completed a Licensed Practical Nurse Program (Copy of Certification in the State of Mississippi).
- ❖ Must have no known physical/mental limitations that interfere with their ability to lift, transfer or provide any other assistance to the client. If the individual indicates any physical mental limitations, statement must be received from their primary care physician treating that condition indicating their ability to perform the duties of a respite provider.

4. RN- Registered Nurse

- ❖ Must be at least 18 years of age.
- ❖ Must have RN License in the State of Mississippi.
- ❖ Must have no known physical/mental limitations that interfere with their ability to lift, transfer or provide any other assistance to the client. If the individual indicates any physical/mental limitations, statement must be received from their primary care physician treating that condition indicating their ability to perform the duties of a respite provider.

18.0 TRANSITION ASSISTANCE SERVICES

Transition Assistance Services are services provided to a Mississippi Medicaid eligible nursing facility resident to assist in transitioning from the nursing facility into the Independent Living or the Traumatic Brain Injury/Spinal Cord Injury Waiver Program.

Transition Assistance is one-time initial expense required for setting up a household. The expenses must be included in approved Plan of Care.

*****Transition Assistance Services are capped at $800.00*** **one-time initial expense per lifetime.**

Transition Assistance Services include:

1. Security Deposits that are required to obtain a lease on an apartment or home.
2. Essential furnishings and moving expense required to occupy and use a community domicile.
3. Set up fees or deposits for utility or service access (e.g. telephone, electricity, heating).
4. Health and safety assurances, such as pest eradication, allergen control, or one-time cleaning prior to occupancy.

(Essential items for an individual to establish his/her basic living arrangement includes such items as a bed, table, chairs, window blinds, eating utensils, and food preparation items). Diversional or recreational items such as televisions, cable TV access or VCR's are not considered furnishings.

Need for this service: All items and services covered must be essential to:

1. Ensure that the individual is able to transition from the current nursing facility.
2. Remove an identified barrier or risk to the success of the transition to a more independent living situation.

To be eligible:

1. Individual must be a current nursing facility resident whose NF services are being paid by Medicaid and want to transition on the Independent Living or Traumatic Brain Injury/Spinal Cord Injury Waiver.

In order to provide sufficient time to coordinate and plan appropriate transition services, the transition service must occur within 90 days of

discharge but must be completed by the day the individual relocates from the institution. Persons whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other

insurance, wholly or partially, are not eligible for this service. Transition services will be considered provided once the individual has transitioned from the nursing facility to the waiver.

Exclusions: Transition Assistance is not available to residents whose stay in a nursing facility is ninety (90) days or less.

18.1 DESCRIPTION OF TRANSITION ASSISTANCE SERVICES

Deposits

Deposits include security deposits for rental and utilities including basic telephone service. Security deposits or utility deposits must be in the applicant's name.

Security deposits may be paid as long as the payment is specifically called a security deposit and not rent, the payment is for a one-time expense, and the amount of the payment is no more than the equivalent of two months rent. Transition assistance services cannot pay for rent.

Transition assistance services can be used to pay for arrears on previous utilities if the account is in the client's name and the client will not be able to get the utilities unless the previous balance is paid. Transition assistance services cannot pay the first month's payment on utilities.

Transition assistance services can be used to pay for a telephone since it is a basic need but minutes or services on the telephone cannot be paid for.

Transition assistance services cannot pay for any charges for upgraded services beyond the basic service.

Transition assistance services funds can be used to pay for initial setup or reconnection fees to propane or butane service including the minimal supply of fuel if the utility company has a policy that requires a minimal supply of fuel to be delivered during the initial or reconnection service call. Transition assistance services funds cannot be used to top off a tank with fuel when the individual's home is connected and has a supply of butane or propane.

Transition assistance services can pay for pet deposits only if the pet is a service animal essential to the client.

Household Needs

Household needs include basic furniture/appliances. This includes bedroom furniture, living room furniture, kitchen furniture, refrigerator, stove, washer, dryer, etc.

An applicant may request a specific brand or type of appliance, furniture or other Transition assistance services item as long as the applicant's needs are met within the cost limit.

Transition assistance services items may be placed in someone's home other than the applicant only when furnishings are not available and are necessary for the applicant to transition to the community. Transition assistance services cannot pay for items that would only be used by the other person.

If existing items are not usable and the lack of a usable basic/essential item creates a barrier keeping the individual from transitioning to the home and community, the item is considered a need.

House wares

House wares can include pots, pans, dishes, silverware, cooking utensils, linens, towels, clock and other small items required for the household.

Small Appliances

Small appliances include a microwave oven, electric can opener, coffee pot, toaster, etc.

Cleaning Supplies

Cleaning supplies include a mop, broom, vacuum, brushes, soaps and cleaning agents.

18.2 SERVICES AND ITEMS NOT INCLUDED IN TRANSITION ASSISTANCE SERVICES

Transition assistance services does not include any items or services that will be included under waiver services such as adaptive aids, minor home modifications, and medical supplies/equipment.

Transition assistance services does not include any recreational items including television, VCR or DVD player, games, computers, cable TV, satellite TV, exercise equipment, vehicles or other modes of transportation.

Transition assistance services will not cover the cost of repairs on the client's dwelling.

Transition assistance services funds cannot be used for food. The OSDP Counselor may refer the client to the Department of Human Services for food stamp assistance and any local food pantry resources.

18.3 PREPARING THE HOME FOR TRANSITION

Preparing the home for transition can include the following services:

- Moving expenses which include the cost of moving the applicant's items from another location or delivery charges on large purchased items.
- Pest eradication, if the applicant's place of residence has been unattended and some type of extermination is needed.
- Allergen control, if the applicant's place of residence has been unattended or the applicant is moving into a place that poses a respiratory health problem or
- One time cleaning, if the applicant's place of residence has been unattended or the applicant is moving into a private home or apartment where pre-move-in cleaning should not be expected, e.g., a family friend has an empty house available but cannot provide the cleaning.

18.4 TRANSITIONING ASSISTANCE SERVICES FORM – ESTIMATED COST OF ITEMS AND SERVICES

The OSDP Counselor may use the Transition Assistance Services Form (See Resource Guide) to assist with planning and determining the services needed and estimated cost. The amounts must be reasonable estimates of the cost of basic items and services. The list may be used to assist the applicant in identifying specific needs, but the Counselor will enter a description and amount only for the items and services identified by the applicant.

18.5 CHANGES TO THE TRANSITIONAL ASSISTANCE SERVICES

Supervisory approval is required to authorize delivery of transition assistance services after the nursing facility discharge.

18.6 FIVE DAY MONITORING REQUIRED BY COUNSELOR AFTER TRANSITION

The Counselor must monitor the clients within (5) five work days of the discharge date to be sure that all services and items authorized were received and the client has transitioned successfully. If the client reports that any items have not been provided, the Counselor must follow-up to resolve the issue.

Once the Counselor confirms that all items/services have been delivered, the Counselor pays the Authorization in AACE and submits the authorization and all documentation to OSDP Madison for Medicaid Reimbursement.

18.7 FAILURE TO TRANSITION FROM THE NURSING FACILITY

While the Counselor makes every effort to confirm that the client has definite plans to leave the nursing facility, there may be situations in which the client changes his mind or has a change in his health making it impossible for him to relocate to the community as planned. In this situation, the Counselor must contact any vendor that has provided a service and stop the delivery of the services. No additional service should be provided/purchased.

MDRS via the Counselor must attempt to return any item(s) purchased on behalf of the individual and collect a refund for the amount of the purchase. MDRS must also attempt to recoup security, utility and other deposits paid on behalf of the individual.

- If the Counselor is unsuccessful in returning the item(s) for the amount or the deposits paid on behalf of the individual cannot be recouped, MDRS is responsible for paying for the item(s) or deposits paid. The Counselor must attach to the authorization when submitting to Madison case note documentation stating that the item(s) could not be returned, or the deposits could not be recouped. Any items obtained from the client may be used to serve individuals whose needs are similar to those of the individual for whom the items were purchased or must be dedicated to assisting other individuals to establish a home.
- If the Counselor is able to return the item(s) or receives the deposits back, the refund for money must be made payable to: Mississippi Department of Rehabilitation Services. A claim will not be billed to Division of Medicaid.
- If the individual is only in the home for a few days and returns to the nursing facility, the individual can keep the item(s) purchased or donate them to other individuals to help establish a home. The Counselor must work with the client to determine what item(s) they should keep and what items should be used for other clients.

The Counselor must explain the purpose and limitations of transition assistance services to the individual when determining their need for the service(s).

The applicant may appeal a decision regarding a needed item or service, but transition services should not be delayed due to the appeal.

19.0 PROSTHETIC AND ORTHOTIC & APPLIANCES

The provision of Prosthetic and Orthotic Devices in an appropriate Independent Living Service.

OSDP staff will follow the same guidelines and procedures set forth in the OVR/OVRB Resource Guide and the Fee Schedule Amputee Clinic Section and fees for Orthotic Procedures L0000-L4999, that specify guidelines regarding Prescriptions, Authorizations, Physical Therapy, Checkout Sessions, Appointments and Fees.

*The IL Counselor should provide the client receiving a prosthetic or orthotic device with sufficient information so the client can make **Informed Choices** regarding the provision of this service. In some instances, a physician or prosthetist may refer the client. A client who was originally referred to OSDP by a prosthetist should have the new appliance purchased from that company unless there are documented reasons to the contrary, ex. The client chooses to use another prosthetic company.*

If the individual has experienced any recent physical problems or changes, a current evaluation and medical records should be obtained from the primary treating physician that indicates their current physical condition.

Any client with amputations resulting from diabetes should be evaluated prior to a prosthetic fitting by an internist or their primary treating physician, to determine that there have been no exacerbations of the physical condition that would affect the successful fitting of a new appliance. The Counselor may obtain current medical information from their primary treating physician that may reflect that there have been no exacerbations of their physical condition.

When determining if a prosthetic or orthotic appliance will benefit an individual in terms of improving their ability to function more independently in the family or community, the following should be considered:

1. *Is the person medically ready to wear a prosthesis?*

2. *Will a prosthetic or orthotic fitting be beneficial in terms of functioning more independently in the home and community?*

3. *Prescription for the prosthetic or orthotic device*
4. *Recommendations for appropriate training in the use of the prosthesis or orthotic device.*

(See fee schedule for L codes when purchasing orthotic and/or prosthetics)

19.1 DETERMINING ELIGIBILITY FOR INDIVIDUALS WITH HEARING IMPAIRMENTS

In order to determine eligibility, the Counselor must obtain a valid ENT report signed by a licensed Otolaryngologist. This report can be furnished by the client, or the Counselor can authorize for a comprehensive ENT examination.

A. If the hearing loss is between 40-50 dB in the better ear and the speech discrimination scores are between 75% and 85%, this case would normally be served by the cross-over Counselor.

B. If the hearing loss is 55dB or greater in the better ear speech discrimination score is between 50% and 75%, this case would normally be served by the RCD.

19.2 DEGREES OF HEARING LOSS

0 dB to 25 dB	Normal limits
26 dB to 40 dB	Mild loss
41 dB to 55 dB	Moderate loss
56 dB to 70 dB	Moderately severe loss
71 dB to 90 dB	Severe loss
91+	Profound loss

Difficulty in Speech Discrimination

90 to 100%	Normal limits
75 to 90%	Slight difficulty, comparable to listening over a telephone
60 to 75%	Moderate difficulty
50 to 60%	Poor discrimination, marked by difficulty in following conversation
Below 50%	Unable to follow running a speech

19.3 COMPLETING YOUR ENT REPORT FORM

1. Page one - Background information (should be completed by the Counselor prior to the examination).
2. Page two - Audiogram and pure tones scores.

(O) represents right ear
(X) represents left ear
[ ] represents bone conduction (sound introduced in the temporal lobe).

MDRS uses the pure tone scores at [500hz, 1000hz, 2000 hz], which are referred to as the *Speech Range*, to determine if the client's loss causes serious limitation in their ability to function or move toward functioning on the home or community.

Pure Tone Averages are determined by adding the scores of these ranges and dividing by three. This is called a three-frequency average. If there is a presence of loss in at least one of the frequencies in the speech range that drops sharply at 4000 hrtz, the Counselor should do a four-frequency average.

Several terms are used in the section:

- *Air* refers to the result of the test for air conduction using pure one averages.

-*Bone* refers to the results of the test for bone conduction.

3. Page three

1) Additional test results – this is not a part of most routine ENT evaluations. If the physician recommends additional testing, the recommended procedure would be authorized in advance on a separate authorization.

2) Hearing aid specifications – This section is also not needed as part of the ENT evaluation. If the ENT group will be the "informed choice" vender, the recommended fitting should be listed in this section. If the ENT group is not the "informed choice" vendor, this section will not be completed.

3) Hearing for speech – This section is where the audiologist will score the speech discrimination test. SD scores are stated as percentages (%). The signature of the Audiologist is required at the bottom of this page.

4. Page four - Prognosis and recommendation by the diagnosis Otolaryngologist.

Terms used in this section:

- *Conduction* refers to the outer and middle ear.
- *Nerve* refers to the inner ear.
- *Mixed* refers to both the conduction and nerve areas.
- *Stable* means that the loss has stabilized and might be improved with surgery.
- *Progressive* means that the loss can be expected to become worse unless corrected by surgery.
- *Permanent* means that the loss has stabilized, but surgery will not benefit it.
- *Diagnosis* refers to the physician's medical opinion as to cause of hearing loss.
- *Prognosis* refers to the physician's medical opinion as to expected outcome of recovery.

If the ENT Physician recommends surgery or hearing aids, the Counselor must still establish eligibility based on hearing loss in the better ear, OSDP is not bound by the ENT physician's recommendation if:

1) The client is not eligible for services.
2) The client does not elect to follow the recommended procedure.

19.4 AUTHORIZING FOR ENT EVALUATION

ENT Evaluations: Which CPT Codes To Use

For comprehensive Otological and Audiological visit for a *new patient* * to the same office, authorize:

- **99203** Otological evaluation
- **92557** Audiological evaluation
- 92507 Speech Therapy sessions
- 92508 Auditory Training

If the Otolaryngologist and the Audiologist are in different offices, the Counselor would authorize for the CPT procedures on separate authorizations.

If the client is returning to the same Otolaryngologist they are now considered to be an established patient, authorized:

- **99213** (office visit/outpatient visit/typically 15 mins).

***The fees listed in the fee schedule should always be used unless the vendor's usual and customary fee is less than that listed in the fee schedule**.

19.5 AUTHORIZATIONS FOR HEARING AIDS AND OPTIONS

MDRS prices for recommended hearing aids should be established according to the following guidelines:

	Markup
Monaural Fitting – Vendor's invoice cost from the manufacturer plus	$375.00
Binaural Fitting – Vendor's invoice cost from the manufacturer	$575.00
Additional for Digital Aids	$200.00

The MDRS markup includes cost of impressions, postage, insurance, batteries, and a One-year warranty.

In keeping with the established policy for purchasing hearing aids and options, MDRS will pay the vendor's invoice cost for the hearing aid and options which are recommended and agreed upon by the Counselor plus the appropriate markup for monaural or binaural aide.

Counselors should obtain the factory cost (invoice) from the hearing aid dealer and authorize for the aid/aids.

The following statement should be on the authorization:

"INVOICE TO ACCOMPANY STATEMENT OF ACCOUNT"

Counselors should receive an actual copy of the invoice with the Statement of Account from the hearing aid dealer and attach it to the Statement of Account when submitting for payment. A copy of the invoice should also be placed in the case file.

The following is a partial list of other optional and assistive devices with prices:

Ear-mold (When authorized separately)	$40.00
Telephone switch (When auth. Separately)	$25.00
Bi-Cros (invoice price plus monaural markup)	
Hearing aid repairs . . factory invoice cost plus	$30.00

***Note that ear-mold(s) would not be authorized for in-the-ear aids.**

If an option is listed as being more than these prices, the actual manufacturer's invoice cost for the option may be paid.

All Authorizations for hearing aids MUST include the make and model of the aid, monaural or binaural markup, and cost of the aid. Example authorizations are given below:

Siemens BTE analog aid	$380.00
Monaural markup	$375.00
TOTAL	$755.00

Resound digital aid (x2)	$1,380.00
Binaural markup	$ 575.00
Additional markup	$ 200.00
TOTAL	$2,155.00

Digital/Programmable Hearing Aids

Digital/Programmable hearing aids may be more appropriate for some types of hearing loss configurations; however, they are not required for the majority of clients with hearing loss. These aids are more expensive and require much more time to adjust properly after the initial fitting. For these reasons, an additional markup of $200 has been allowed to compensate the vendor for up to 4 additional office visits to cover services rendered after the initial fitting.

Any Digital/Programmable hearing aids in excess of $2,300.00, including markups must be staffed with the State Coordinator of Deaf Services (SCD) before an authorization is issued.

19.6 FOUR (4) REASONS FOR REPLACING HEARING AIDS

a. If the aid is at least four years old
b. If the aid has been repaired at least once at the cost of the user*
c. If the aid now being worn is no longer appropriate for the client's hearing loss
d. If technology has improved to the point that a new aid is significantly better.

*If the client purchases an extended warranty, his/her out-of-pocket expenses are automatically considered to meet the requirements "for part b".

19.7 CLIENT PARTICIPATION

Client participation can be an appropriate way to utilize case service funds if the client can afford to participate in the payment of his/her hearing aids. If you do receive some amount of client participation by the client, MDRS is still ultimately responsible for the hearing aid payment.

19.8 WEEK FOLLOW-UPS/THIRTY DAY FOLLOW-UP

The purpose of the two week follow-up is to show that the vendor has successfully fitted the client with the prescribed hearing aid and has met with the client within two weeks to confirm his/her satisfaction with the fitting. The form should be included along with the initial authorization and sent directly to the vendor. Two weeks after the fitting, the form should be completed by the client in the hearing aid dealer's office, not sent to the client in the mail. Again, the two week follow-up form is your confirmation that the client has received the proper services for which you are paying. If the client is not satisfied with his hearing aid or the services of the vendor, the two week follow- up serves as the client's mechanism to express his feelings in writing.

The thirty day follow-up is conducted by the Counselor with the client, thirty days after the initial fitting, to confirm that the client is still satisfied after thirty days. Because it serves as one of the required counseling contacts prior to moving a client to employed status, the thirty day follow-up should be conducted in a one-on-one counseling session not over the phone. Most often, during a thirty day follow-up session, the client will have questions and concerns about his new aids that only the Counselor is qualified to answer.

20.0 CASE FILE FOLDER

Each client's folder will have a label affixed to the tab on the folder. The label will include: the client's name, address, county, and district number. The following will be stamped on the outside of the client's file folder and the appropriate information recorded beside the headings:

- Client's Social Security Number
- Client's Telephone Number
- SSI/SSDI Status
- Case Status Dates (updates as status changes are made)
- Medicaid Number (if applicable)

20.1 CASE NOTES

Entries made are to include a record of all Counselor contacts with and/or behalf of the client. Case notes should include the counseling sessions, monthly contacts, telephone conversations, and reports of progress. Case notes will be filed on top of all other records on the left side of the folder. All case notes must be entered into the electronic case file (AACE), printed, and placed in the hard copy case file. All entries will be dated and the place of contact recorded (Category). The nature of the Case notes will be recorded in the Summary Section. AACE records the author of the Case notes as the person logged in the system. If another staff is entering the Case note on the Counselor's behalf, the Case notes will be signed by the Counselor. Record the first initial and last name.

20.2 CASE SERVICE RECORD ORGANIZATION

The case record should be organized in such a way as to allow for easy access of information. All materials should be filed in reverse chronological order (most recent on top) based on the date information was received.

The Client Case File maintained by the OSDP Counselor should contain all assessment and eligibility information.

The case file is considered to be deficient if it does not contain the following information, at a minimum:

- **Running Record – Case notes**

  - Documentation of Quarterly Reviews
  - Recertification Notes
  - Monthly Contacts

***Some clients correspond with their Counselor via e-mail. If this occurs the e-mail shall become a part of Case notes and filed accordingly.**

PAGE 1 - Application

- Referral Form
- Envision Sheet
- Application for Services
- Statement of Understanding
- Consent to Disclose Form
- HIPPA
- Insurance Declaration Form
- Appendix D/Medicaid Payment Authorization Sheet
- Medical Records
- Emergency Preparedness Form

PAGE 2 - Case Notes

- Case Notes
- AT Reports, Project Start, etc.
- Notice of Action Letter

PAGE 3 – Pre-Admission Screening (PAS)

- PAS Application
- Informed Choice

PAGE 4 - Physician's Form

- Physician's Summary
- TBI/SCI Verification Form
- Respite Tier Form

PAGE 5 - Plan of Care (POC)

- POC (Handwritten)
- POC (Electronic)
- Added Services

PAGE 6 – Personal Care Attendant (PCA) Certification

- PCA Cert (not application)
- Change of Address
- PCA Task Assignment Sheet

PAGE 7 - Time Logs

- PCA Time Logs/payment sheets
- Respite Time Logs/payment sheets

PAGE 8 - Financial Documents

- Authorizations
- EOB
- FIN
- AT Reports
- Quotes/Bids
- Prescription

PAGE 9 – Medicaid Correspondence

- NOD
- 105
- Two-Way Communication

PAGE 10 – Independent Living Plan (ILP)

- ILP
- Certificate of Eligibility

21.0 AUTHORIZATION OF SERVICES

All services purchased for OSDP/IL clients will be authorized in AACE either simultaneously with, or prior to, such purchases. Only a Counselor or other member of the OSDP/IL professional staff will authorize the purchase of services. Authorizations will be issued only after a case has been placed in Application Status. Authorizations are to be signed by the Counselor in the top and bottom sections where indicated.

All authorizations for specialized medical supply (SMS), home modifications, and durable medical equipment (DME) must be forwarded to, and reviewed by, the District Managers prior to submission to the State Office for payment.

District Managers are responsible for making sure all authorizations are submitted with the necessary documentation including remittance forms, final inspections, a current envision sheet and approval to pay vendors.

Any authorization with missing documentation will be sent back to the District Manager for correction. **(Authorizations will not be held at the State Office due to missing or incorrect information.)**

All authorizations for SMS will be reviewed by the counselor, and then forwarded to the vendor, on the first day of each month.

Authorizations for SMS should **not** be printed for more than one month at a time for the following reasons:

a) The client's needs may change; therefore, the authorization will need to be amended.

b) Change in counselors. If transferred, a counselor cannot amend another counselor's authorization.

c) Overstock in supplies. If client has too many supplies, the authorization should not be submitted for the following month; thus saving money.

The file copy will be placed in an outstanding authorization holding file until the original copy is received back from the vendor, paid in AACE or the authorization is cancelled.

All SMS payments must be paid in AACE then forwarded to State Office by the 15th of each month. This includes the original signed authorization and two copies.

When making payments in AACE, enter all corresponding invoice numbers on the AACE payment page.

All authorizations for SMS or DME must include client's Medicaid, Medicare and private insurance information directly on the authorization. Remember:

a) Medicare will not pay for adult diapers or blue pads, so an Explanation of Benefits (EOB) is not needed.
b) State Medicaid will not pay for adult diapers or blue pads for anyone 21 and above so an EOB is not needed. Please check the client's date of birth.
c) **State Medicaid will pay for catheters, leg bags, adult diapers, blue pads, etc for all clients under 21**. Please check client's date of birth.

When using waiver funds, a copy of the approved Plan of Care (POC) should be attached to Madison's copy of the authorization. Keep in mind, the services must be approved on the most recent POC.

Check the dates of services rendered to the authorization date. If the date of service is prior to the authorization date, verify that a draft authorization was done, and note on the statement of account that a draft is in the file.

If for some reason the authorization was not issued in the electronic case file prior to or simultaneously with provision of services, the following should occur:

a) An authorization must be initiated and placed in DRAFT status.

b) The DRAFT authorization should then be forwarded to the District Manager with an explanation as to why the authorization that was verbally authorized was not issued simultaneously in the electronic file, AACE. This explanation can be entered in the comments section of the authorization.

c) The District Manager then must review the authorization and explanation and either approve or disapprove the issuance of the authorization.

d) If the District Manager approves the authorization, the authorization can then be issued in AACE and mailed to the vendor.

e) When the Authorization/Statement of Account is signed and returned to the Counselor prior to submitting to finance, DRAFT in file must be entered/written on the authorization. The dates of services should be recorded as the actual date the service was provided which in most case is prior to the authorization begin dates.

When bills are received from vendors to verify the service was authorized and this is a valid expense, the authorization number should be recorded on the bill, and the Counselor should initial the bill.

When checking the status of a vendor payment, the counselor must:

a) Check with his/her District Manager on the status of a vendor's payment;

b) Managers will check to see if the authorization was received by the State Office;

c) Managers can check with Finance after the above has been checked.

21.1 TIME LIMIT FOR FILING CLAIMS

Claims for covered services will be paid by DOM only when received within twelve (12) months of the through date of service.

The following are the only reasons allowed consideration for overriding the timely filing:

- Claims filed within twelve (12) months from the date of service but denied can be resubmitted with the internal control number (ICN) from the original denied claim recorded on the face of the resubmitted claim.

- Claims over twelve (12) months can be processed if the consumer's Medicaid eligibility has been approved retroactively by the Division of Medicaid. Proof of retroactive determination should accompany the claim and be filed within twelve (12) months from the date of retroactive letter.

Claims submitted two (2) years from the date of service are not reimbursable unless the consumer's Medicaid eligibility is retroactive.

21.2 MDRS/OSDP FILING CLAIMS TO MEDICAID

After receiving payment or denial from all third party sources, MDRS is required to file a claim with DOM. The amount of the third party payment must be indicated in the appropriate claim field. The claim is processed, and Medicaid either pays the balance due on the claim (the total Medicaid payment amount less the third party payment amount) or makes no additional payment if the third party payment is equal to or greater than the total amount due to Medicaid. In either situation, the consumer's history of services is updated.

22.0 CASE RECORD CLOSURES FOR INDEPENDENT LIVING SERVICES

A client's case shall be closed when it has been determined by the Counselor that planned services are completed, as appropriate, or that additional services are either unnecessary or inappropriate.

Cases may be closed at different stages in the rehabilitation process:

- From Applicant Status
- After Eligibility From Pre-Service Listing
- After Eligibility but prior to ILP development
- After ILP development but prior to ILP services being initiated
- After Initiation of ILP services

There are two types of closure statuses:

- Closed Goals Met
- Closed Other Than Rehabilitated – Goals Not Met

There must be adequate documentation in the case record regarding the case closure. Documentation may be on AACE forms and case notes.

Required documentation generated from AACE includes the following:

- AACE Closure Report
- Notification of Closure Letter
- Closing Statement for Goals Met
- Certificate of Ineligibility
- Certificate of Ineligibility/ILP closing amendment
- AACE Case Summary Report at closure
- AACE Case History Report

All documentation regarding case closure must be clearly **stated** and **written** in a manner that presents a thorough explanation of the reasons or situations regarding

the closure. All closure documentation must be based on the contents of the case record.

22.1 CLOSURE-GOALS MET

Cases closed, as Goals Met must meet the minimum criteria listed below:

- The individual has been determined eligible.
- The individual was provided an evaluation/ assessment for services.
- The individual was provided counseling and guidance/case management as an essential IL service.

There must be documented evidence that the Counselor personally addressed the following issues with the consumer or, as appropriate, the consumer's representative:

- The client's ability to function independently in the home or community or continue in employment has improved.
- Consumer indication of agreement/disagreement with the decision to close their case.

The consumer must be informed in writing of the case closure decision in a letter labeled **"Closing Statement."**

The closing statement must be **dated** and **signed** by the Counselor and must include:

- Indication that the consumer agreed/disagreed with the decision.
- Indication that the provision of services contributed significantly to improving their ability to function or continuing functioning in the home and community.
- Information regarding benefits/insurance.

22.2 CASE FILE DOCUMENTATION FOR CLOSURE-GOALS MET

- Documentation throughout the case file must show that the services planned and provided did in fact contribute significantly to the client's ability to functioning more independently in the home or community.

- The case file should document the reason(s) any planned service(s) was not provided or services closed not met.

- If counseling and guidance were planned, there must be documentation to indicate that this service was provided at appropriate intervals. Any delays or interruptions of services should be documented.

- There must **always** be documentation of essential counseling and guidance before a case can be closed as rehabilitated, Goals Met.

- Appropriate **contact** by agency staff should be **documented** as required (at least every 90 days and more often if warranted by client's disability or services being provided, ex. waiver services). Any reason for extended periods of time without contact should be documented.

- Documentation at case closure must show that the Counselor personally contacted the consumer at the time of closure and that case closure was discussed.

- All documentation must indicate that the appropriate **mode** of communication was used.

- The appropriate agency-closing letter is labeled **"Closing Statement"** and must be used to notify the consumer of closure. This letter contains information required by law for closure notification.

- Documentation of the consumer and Counselor contact at closure along with the **"Closing Statement"** letter should meet the documentation requirements.

22.3 CLOSURES – GOALS NOT MET

There are two reasons for closures – goals not met:

1. Because eligibility requirements are not met and

2. For reasons other than eligibility criteria not met (often referred to as intervening reasons)

Closure Reasons Because Eligibility Requirements are Not Met

Ineligibility determination must be based on one of the following:

- No disabling condition

  To close cases as "no disabling condition" medical documentation must indicate that the applicant does not have a severe physical or mental impairment.

- No serious limitations in their ability to function independently in the family or community or continue in employment;

  To close case as "no serious limitation in their ability to function", case documentation must show that the applicant's physical or mental condition does not cause serious limitations in their ability to function independently in the family or community.

- The delivery of IL Services will not significantly assist the individual to improve his or her ability to function, continue functioning or move towards functioning in the family or community.

- Disability is too severe/unable to benefit from IL services.

  To close a case as "disability too severe" requires clear and convincing evidence of the severity of the disability.

  "Clear and convincing evidence" means that MDRS shall have a higher degree of certainty before it can conclude that an individual is incapable of benefiting from services in terms of improving their ability to function independently in the home and community. The clear and convincing standard constitutes the highest standard used in our civil system of law and is to be individually applied on the case-by-case basis. It would require evidence from more than one source. Also, a demonstration of

clear and convincing evidence requires the exploration of the applicant's abilities, capabilities, and capacity to perform in the home and community with any necessary supports in real life settings.
Medical documentation is required if an applicant has a severe physical/mental condition.

Closures because eligibility requirements are not met require full consultation with the applicant. This consultation must be recorded.

Written notification must include:

- The reason for the ineligibility determination
- Appeal rights
- Availability of the Client Assistance Program
- Referral to other agencies and facilities

22.4 CLOSURE REASONS OTHER THAN ELIGIBILITY CRITERIA NOT MET (INTERVENING REASONS)

Unable to locate, contact, or moved: This reason is used when the individual has moved without a forwarding address or is otherwise unavailable. Also, use this code for persons who have left the state and show no intentions of continuing in their IL program. It is also used when the individual leaves the state and gives little evidence of returning in the foreseeable future.

The case file should indicate that a minimum of 2 letters and 2 telephone call attempts were made prior to closure. A telephone call with no answer is not considered an attempt.

- A closing letter is not required

Refused Services or further services: This reason is used when the individual declines to accept, participate in, or use independent living services. **Prior to closing a case for refused services, the documentation must indicate that the consumer or his representative has communicated verbally or in writing that he/she does not want services.**

- A closing letter is not required

Death: This reason requires case file documentation. **Documentation may include copy of the obituary, case note indicating notification by family member, etc.**

- A closing letter is not required

Individual in Institution: This reason is used when an individual has entered an institution and will be unavailable to participate in an IL program for an indefinite or considerable period of time. An institution includes a hospital, a nursing home, a prison or jail, a treatment center, etc. **Documentation may include a case note indicating notification by client, a family member, etc.**

- A closing letter is not required

Transferred to another agency: This reason is used when an individual needs services that are more appropriately obtained elsewhere. Transfer to the other agency indicates that appropriate referral information is forwarded to the other agency so that agency may provide services more effectively.

- A closing letter is not required

Failure to cooperate: Using this closure reason indicates individual actions (or non-actions) that make it impossible to begin or continue an IL program. Failure to cooperate includes repeated failures to keep appointments for assessment, counseling, or other services. (Ex. medical appointments) Efforts by the Counselor to overcome these actions or non-actions are required and must be documented in the case file. **The case file must indicate that a minimum of 3 legitimate (by letter and/or telephone call) attempts were made prior to closure for this reason. At least one of these attempts must be by the Counselor. A telephone call with no answer is not considered an attempt.**

- A closing letter is not required

All other reasons: This is to be used for all reasons not covered above. **The case must be well documented to explain the closure reason. Do not use this reason when the consumer's case record should be closed for one of the previous reasons.**

- A closing letter is not required

22.5 AACE CLOSURE PAGE

Facility/Agency Furnishing Services - This item involves identifying sources that actually delivered rehabilitation/independent living services to the client not the source paying for the service.

Services Furnishing – Public and Private Sources - Select the choice if the client received some services in a public rehabilitation facility and some in a private rehabilitation facility or if a client attended both public and private clinic during the rehabilitation process.

Educational Institutions (except Business/Vocational Schools) -Includes colleges, universities, junior colleges, elementary or high schools and schools for the mentally and physically disabled.

Business/Vocational Schools - Includes business, commercial, vocational, technical or trade schools.

Hospitals and Sanatoriums - Includes hospitals, mental hospitals, other chronic condition or specialized hospitals.

Health Organization and Agencies (except Rehabilitation Facilities) – Includes community mental health centers, State Children's Agencies and any other public and private health organizations and agencies.

Community Rehabilitation Facilities - Includes any location at which a variety of services are provided to help individuals overcome their functional limitations in reference to their disabilities.

Welfare Agencies – Includes State and local Welfare agencies, labor unions, civic and community welfare organizations.

Other Public Organizations and Agencies (not specifically education, health or welfare) – Includes State employment agency, State Vocational Rehabilitation Agency, Social Security, etc. Since this pertains to only public sources, legitimate selections would be "services furnished – public sources."

Other Private Organizations and Agencies (not specifically education, health or welfare) – Includes employee, prosthetic and orthotic companies, etc. Since this pertains to only private sources, legitimate selections would be "services furnished – private sources"

Individual (Private) - Includes physicians and other persons providing services who cannot be classified with an organization or agency. Since

this pertains to only private sources, legitimate codes would be “services furnished – private sources.”

Donations - Cash Donated: enter the amount that the client has received from any outside resource to help purchase planned services.

Estimated Value of Goods and Services – Estimate the value of goods and services purchased with the cash donation.

23.0 ABBREVIATIONS, ACRONYMS, & DEFINITIONS

AACE	Accessible Automated Case Environment
ACB	American Council of the Blind
ACT	The Rehabilitation Act of 1973, as amended
ADA	Americans with Disabilities Act
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
AW	Ability Works
AFDC	Aid to Families with Dependent Children
AGI	Adjusted Gross Income
ALF	Assisted Living Facility
AMRC	Addie McBryde Rehabilitation Center for the Blind
ARC	Association for the Rights of Citizens with Developmental Disabilities
AT	Assistive Technology
AL	Assisted Living
BEP	Business Enterprise Program
BIA	Brain Injury Association
BSC	Basic Service Grant
CAP	Client Assistance Program
C/E	Certificate of Eligibility
CEC	Comprehensive Evaluation Center
CEU	Continuing Education Unit
CIL	Center for Independent Living
CF	Count Fingers

Core Services – IL services defined in Section 7 (17) of the Act means: information and referral services; IL Skills Training; peer counseling (including cross-disability peer counseling); and, individual and systems advocacy.

CSR – Consumer Service Record maintained for an eligible consumer receiving IL services and meeting the requirements of 34 CRF 364.53

CMI	Chronic Mental Illness
CPM	Certified Public Manager
CRP	Community Rehabilitation Program
CRC	Certified Rehabilitation Counselor
CRS	Case Review Schedule
CSAVR	Council of State Administrators for Vocational Rehabilitation
CSLR	Counselor
CCWAVES	Commission of Certification of Work Adjustment and Vocational Evaluation Specialists
CD	Consumer Directed

COLA	Cost of Living Adjustment
CVE	Certified Vocational Evaluator
DB	Decibel
D/B	Deaf-Blind
DD	Developmental Disability
DDS	Disability Determination Services
DFA	Mississippi Department of Finance and Administration
DHS	Mississippi Department of Human Services
DM	District Manager
DMH	Mississippi Department of Mental Health
DOM	Division of Medicaid
DSU	Designated State Unit
E & D	Elderly & Disabled
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FFP	Federal Financial Participation
FHA	Federal Housing Administration
FTE	The equivalent of one person working full-time for one year
FFY	Federal Fiscal Year
HCBS	Home and Community-Based Services
HCBS 105	Admit and Discharge Form
HMO	Health Maintenance Organization
HIPPA	Health Insurance Portability and Accountability Act
HUD	Department of Housing and Urban Development
IADL	Instrumental Activities of Daily Living
ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility for persons with Mental Retardation
ID/DD	Intellectually Delayed/Developmentally Disabled
IDEA	Individuals with Disabilities Education Act
IPE	Individualized Plan for Employment
IL	Independent Living
ILP	Individualized Independent Living Plan
ILRC	Independent Living Rehabilitation Counselor
LIFE	Living Independence for Everyone
LPC	Licensed Professional Counselor
LOC	Level of Care
LSW	Licensed Social Worker
LTC	Long Term Care
MDRS	Mississippi Department of Rehabilitation Services
MRC	Methodist Rehabilitation Center

Minority – Alaskan Natives, American Indians, Asian Americans, Black (African Groups) Americans, Hispanic or Latino Americans, Native Hawaiians, and Pacific Islanders.

MP&A	Mississippi Protection & Advocacy Systems
MPA	Mississippi Paralysis Association
NF	Nursing Facility
NOA	Notice of Action
NOD	Notice of Determination
NFB	National Federation of the Blind
NLP	No Light Perception
OBRA	Omnibus Budget Reconciliation Act
OSDP	Office of Special Disability Programs
OVR	Office of Vocational Rehabilitation
OVRB	Office of Vocational Rehabilitation for the Blind
OS	Left Eye
OD	Right Eye
OU	Both Eyes
PA	Prior Authorization
PAS	Pre Admission Screening
PAS Summary	Physician Certification (Section X)
PERS	Personal Emergency Response System
PERS	Public Employees' Retirement System
PCA	Personal Care Attendant
POC	Plan of Care
PRTF	Psychiatric Residential Treatment Facility
RAM	Rehabilitation Association of Mississippi
RAMP	Rehabilitation Administration & Management Programs
RCD	Rehabilitation Counselor for the Deaf
RCF	Residential Care Facility
RID	Registry of Interpreters for the Deaf
REACH	Realizing that Empowerment through Accomplishment and Confidence building, it is Honorable to be Blind.

Reporting Year – The most recently completed Federal fiscal project year staring October 1 and ending September 30.

RM	Regional Manager
RN	Registered Nurse
RSA	Rehabilitation Services Administration
OSERS	Office of Special Education and Rehabilitative Services
SGA	Substantial Gainful Activity
SCI	Spinal Cord Injury

SE	Supported Employment
SFY	State Fiscal Year
SILC	Statewide Independent Living Council established in each State as required by Section 704 and 705 of the Act.
SILS	A State Independent Living services program funded under Part B, Chapter 1 of the Title VII of the ACT
SLD	Specific Learning Disability
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SOICC	State Occupational Information Coordinating Committee
SPB	State Personnel Board
SPIL	State Plan for Independent Living
SRC	State Rehabilitation Council
SRT	Speech Reception Threshold
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
START	Success through Assistive Rehabilitation Technology
SWIB	State Workforce Investment Board
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
TDD	Telecommunication Device for the Deaf
TTY	Teletypewriter for the Deaf
TWE	Trail Work Experience
UCL	Uncomfortable listening level
VA	U.S. Department of Veteran's Affairs
VE	Vocational Evaluation
VEWAA	Vocational Evaluation & Work Adjustment Association
VR	Vocational Rehabilitation
VSMS	Vineland Social Maturity Scale
VTI	Vocational Training Instructor
WAIS	Wechsler Adult Intelligence Scale
WC	Workers' Compensation
WEP	Work Experience Program
WIA	Workforce Investment Act
WIIA	Work Incentives Improvement Act
WISC	Wechsler Intelligence Scale for Children
WMS	Wechsler Memory Scale
WRAT	Wide Range Achievement Test

23.1 PAS DEFINITIONS, NEW TERMS AND FUNCTIONALITY

HELP Function – The Help function key is located on the top right side of the screen. The Help function will provide specific help/instructions depending on what screen you are on.

PAS – Pre-Admission Screening. This tool replaces the old Initial Needs Assessment form, Recertification Needs Assessment form and the Physician Certification DOM 260 form.

Application for Potential Beneficiary – When completing an assessment for a new client who does not have Medicaid, select this option.

Application for Medicaid Beneficiary – Select this option if completing a new assessment for a client who already has Medicaid. Make sure the first nine (9) digits of the Medicaid Number are entered correctly from their card.

Remote PAS - Select this option when downloading the PAS application onto your desktop/laptop for you to complete the PAS while in the client's home. Internet service is not needed.

Prior Authorization (PA) – The term Plan of Care is now called Prior Authorization.

PA Request – This is to be used once the client has been approved for Medicaid and the plan of care information is entered.

PAS Submission – Within three (3) working days of completing a PAS application, enter the information into the PAS either online or using the remote PAS application.

23.2 DEFINITIONS FOR AUTHORIZED REPRESENTATIVE

If the applicant/consumer is an adult, their representative is a person who has the authority to make decisions about the consumer and includes a:

- Person the consumer has appointed under a medical power of attorney, a durable power of attorney with the authority to make health care decisions, or a power of attorney with the authority to make health care decisions,
- Court – appointed guardian for the consumer, or
- Person designated by law to make health care decisions when the consumer is in an institution and is incapacitated or mentally or physically incapable of communication.

Legal Representative means any person who has been vested by law with the power to act on behalf of another individual. The term includes a guardian appointed by a court of competent jurisdiction in the case of an incompetent individual or minor; or a parent in the case of a minor; or a person acting under a valid power of attorney. Categories of legal representatives include:

- *Conservator*: means an individual or corporation appointed by a court to manage the estate, property, and/or other business affairs of an individual whom the court has determined is unable to do so for him/herself.

- *Power of Attorney*: means a document which authorizes a person (agent) to act on behalf of another person (the principal). The principal delegates this authority, establishes its parameters, and may terminate it. Its authority is also terminated by death, disability, or incompetence of the principal, unless it is "durable."

- *Durable Power of Attorney*: a power of attorney document which specifically states it is to (1) remain in effect despite the principal's subsequent incapacity or (2) take effect upon the principal's incapacity.

- *Guardian:* means an individual or corporation appointed by a court to see to the needs of a person proven to be incapacitated or in need or continuing care or supervision. A guardianship may be "limited'", addressing only some types of need, an arrangement which is less restrictive than a full guardianship.

23.3 DEFINITIONS VULNERABLE ADULTS AND CHILDREN

Definitions under MISS. CODE ANN, 43-47-5:

"Vulnerable adult" shall mean a person eighteen (18) years of age or older or any minor not covered by the Youth Court Act who is present in the State and who, regardless of residence, is unable to protect his or her own rights, interests, and/or vital concerns and who cannot seek help without assistance because of physical, mental, or emotional impairment.

"Abuse" shall mean the willful infliction of physical pain, injury or mental anguish on a vulnerable adult, the unreasonable confinement of a vulnerable adult, or the willful deprivation by a caretaker of services which are necessary to maintain the mental and physical health of a vulnerable adult. Abuse shall not mean conduct which is a part of the treatment and care of, and in furtherance of the health and safety of a patient or resident of a care facility.

"Neglect" shall mean either the inability of a vulnerable adult who is living alone to provide for him/herself the food, clothing, shelter, health care, or other services which are necessary to maintain his/her mental and physical health, or failure of a caretaker to supply the vulnerable adult with the food, clothing, shelter, health care, supervision, or other services which are necessary to maintain his/her mental and physical health.

"Exploitation" shall mean the illegal or improper use of vulnerable adult or his/her resources for another's profit or advantage.

Definitions under MISS. CODE ANN, 43-21-105:

"Child" and "Youth" are synonymous, and each means a person who has not reached his/her eighteenth (18) birthday. A child who has not reached his/her eighteenth (18) birthday who is on active duty for a branch of the armed services and is married is not considered a child or youth for the purposes of this section.

"Abused child" means a child whose parent, guardian, custodian, or any person for his/her care or support, whether legally obligated to do so or not, has caused or allowed to be caused upon said child sexual abuse, sexual exploitation, emotional abuse, mental injury, non-accidental physical injury, or other maltreatment.

"Neglected child" means a child:

a) Whose parent, guardian, custodian, or any person responsible for his/her care or support, neglects or refuses, when able to do so, to provide for him/her proper and necessary care or support, or education as required by law, or medical, surgical, or other care necessary for his well-being; provided, however, a parent who withholds medical treatment from any child who in good faith is under treatment by spiritual means alone through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practioner thereof shall not, for that reason alone, be considered to be neglectful under any provision of this section; or
b) Who is otherwise without proper care, custody, supervision, or support; or
c) Who for any reason, lacks the special care made necessary for him by reason of his mental condition, whether said mental condition be mentally retarded or mentally ill; or
d) Who, for any reason, lacks the care necessary for his health, morals, or well-being.

23.4 DEFINITIONS – NOTICE OF ACTION/HEARINGS

Independent Living Waiver &
Traumatic Brain/Spinal Cord Injury Waiver

For the purpose of this section (42 CFR 431.201)

Notice means a written statement explaining what action is being taken.

Action means a termination, suspension, or reduction of Medicaid eligibility or covered services.

Date of action means the intended date on which termination, suspension, reduction, transfer or discharge becomes effective.

Request for hearing means a clear expression by the applicant/consumer or his/her authorized representative that they want the opportunity to present his/her case to a reviewing authority.

The applicant/consumer must be informed in writing of a decision that will result in the following:

- Being determined ineligible for services
- The amount (quantity) of the service the client will receive
- The request for particular services being denied
- Being determined ineligible for continued services

23.5 INDEPENDENT LIVING CONSUMER ACHIEVEMENTS/GOALS/OBJECTIVES

Self-Advocacy/Self-Empowerment – Goals involving either improvement in a consumer's ability to represent himself/herself with public and/or private entities or ability to make key decisions involving himself/herself.

Communication - Goals involving either improvement in a consumer's ability to understand communication by others (receptive skills) and/or improvements in a consumer's ability to share communication with others (expressive skills).

Mobility/Transportation – Goals to improve a consumer's access to his/her life space, environment, and community. This may occur by himself/herself or the use of public transportation.

Community Services- Goals that provide for a change in living situations with increased autonomy for the consumer. This may involve a consumer's goal related to obtaining/modifying of an apartment or house.

Educational – Goals of an academic or training nature that are expected to improve the consumer's basic knowledge or increase his/her ability to perform certain skills deemed to increase his/her independence consistent with IL philosophy.

Vocational – IL goals related to obtaining, maintaining, or advancing in employment.

Self-Care – Goals to improve/maintain a consumer's autonomy with respect to activities of daily living such as grooming and cleaning, toileting, meal preparation, shopping, eating, etc.

Information Access/Technology – Goals related to a consumer obtaining and/or using a computer or other assistive technology, devices, or equipment, also a consumer's goal of developing skills in using information technology, e.g. emerging computer screen-reading software.

Personal Resource Management – Goals related to a consumer learning to establish and maintain a personal/family budget, managing a checkbook, and/or obtaining knowledge of available direct and indirect resources related to income, housing, food, medical, and/or other benefits.

Other – IL goals not included in the above categories.