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## **400 SUPPORT COORDINATION**

### **401 Overview**

This chapter defines the role of the Division Support Coordinator and the Support Coordinator's responsibilities for coordinating service provision to persons with developmental disabilities.

### **402 Components of Support Coordination**

The Support Coordinator's roles include but are not limited to the following:

- A. Planning and Coordination
  - 1. Based on assessed need, identifies Cost Effective Services.
  - 2. Develops the Service Plan.
  - 3. Ensures members and families know the steps to report unavailability of services or other problems.
  - 4. Coordinates acute, behavioral health, and long term care services that will assist the member in maintaining or progressing toward his/her highest potential.
  - 5. Reassesses needs and modifies Service Plan as needed.
- B. Brokering Of Services
  - 1. Identifies appropriate community resources for members and families.
  - 2. Obtains all funded services as assessed.
  - 3. Offer a substitute service, when the assessed service is not available.
- C. Facilitation/Advocacy: Addresses and Resolves Issues Timely
- D. Monitors Services for Continuing Appropriateness
- E. Gatekeeping: Assess and Determine the Need for, And Cost Effectiveness of, Services for Members

The Support Coordinator shall:

- A. Follow current Division policy
- B. Comply with all AHCCCS requirements
- C. Complete DES/DDD requirements/paperwork
- D. Document accurately
- E. Complete assigned tasks
- F. Be punctual and available

Support Coordination/Arizona Early Intervention Program (AzEIP)

Service Coordination responsibilities for the AzEIP can be found on the AzEIP Policy and Procedures webpage.

(<https://www.azdes.gov/main.aspx?menu=98&id=2384>).

#### Contracted Support Coordination (Case Management)

A Qualified Vendor provides contracted Support Coordination services to members who are eligible for Division services.

The goal of this service is to coordinate needed assistance to members and their families/responsible persons to help ensure members attain their maximum potential for independence, productivity, and integration into the community.

The Qualified Vendor is responsible for the following:

- A. Assessment in conjunction with the Planning Team, by gathering, reviewing, and evaluating information to assist families/members/responsible persons to determine the member's goals, outcomes and services needed.
- B. Plan Development by facilitating an interdisciplinary team including the family/member/responsible persons and the development of an annual Planning Document. Planning Meeting facilitation may be deferred to the Person Centered Plan Facilitator if the family/member/responsible person so chooses.
- C. Plan Coordination by ensuring that supports, services, activities and objectives identified in the Planning Document are accessible to the family/member/responsible person and are implemented.
- D. Plan Monitoring by ensuring the family/member receives quality supports and services in a cost effective manner in accordance with the Division's Support Coordination supervision by:
  1. Providing opportunities for regular supervision to discuss work done on behalf of families/members through case review and problem solving.
  2. Scheduling monthly discussions with a Division Supervisor or Division Liaison.
  3. Conducting file audits.

The Division will retain various Support Coordination activities including: completing the intake process; determining and re-determining eligibility; authorizing services; and monitoring service delivery.

Only providers who have been awarded a contract for Support Coordination may perform Contracted Support Coordination services.

The requirements/prohibitions for Qualified Vendors related to Contracted Support Coordination and service delivery are as follows:

- A. The Qualified Vendor must avoid any conflict of interest between the delivery of Support Coordination services and the delivery of direct services to the member.
- B. The Qualified Vendor may not deliver direct services and Support Coordination to the same member. However, the Qualified Vendor may deliver both direct services and Support Coordination to members who are enrolled in the early intervention program of the Division.
- C. Unless the Qualified Vendor receives approval from the Division's Assistant Director/Designee, the Qualified Vendor must wait six (6) months before delivering services to a member who previously received Support Coordination services from the Qualified Vendor. This requirement does not apply to services delivered to members who are enrolled in the early intervention program.

#### Navajo Nation Contracted Support Coordination

The Division has an Intergovernmental Agreement with the Navajo Nation to provide contracted Support Coordination services to members who are eligible for Arizona Long Term Services (ALTCS) and are:

- A. Enrolled by the Department of Economic Security with the Navajo Nation to receive case management services.
- B. Affiliated as members of the Navajo Tribe by virtue of being federally recognized Tribal members and who either live on the Navajo reservation or did live on the Navajo reservation prior to placement in an eligible ALTCS setting.
- C. American Indians who are not affiliated members with the Navajo Nation by virtue of being federally recognized members, but currently physically reside on the Navajo reservation or did physically reside on the Navajo reservation but were subsequently placed off reservation in an eligible ALTCS setting.

For members receiving Home and Community Based Services (HCBS) on the reservation or in a nursing facility on or off reservation, the contracted Support Coordinator shall:

- A. Develop and implement a Planning Document.
- B. Coordinate medical needs with the members' Primary Care Provider (PCP).
- C. Assist members/families with identifying qualified providers for ALTCS services, if they are unable to choose a provider without assistance.

- D. Monitor and update Planning Documents in accordance with this Policy Manual.
- E. Assess the cost effectiveness of services and recommend the least costly effective service alternatives.
- F. Inform members of alternative services when the HCBS services exceed 100% of the Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) rate.
- G. Implement necessary corrective action to bring services into compliance.

The Division will retain various Support Coordination activities including: completing the intake process; determining and re-determining eligibility; authorizing services; and monitoring service delivery.

### **403 Planning Team Members**

The membership of the Planning Team will vary depending upon the needs and wishes of the member and/or family.

The Planning Team will include at a minimum:

- A. The member
- B. The member's parent if the member is a minor or legal guardian, if any
- C. The Division Support Coordinator or other appropriate Division representative, who shall serve as plan facilitator and coordinator
- D. Representatives of any service currently authorized or assessed
- E. Any other persons the member/responsible person or the Division select
- F. Additional team members may participate in the planning team meeting:
  - 1. Direct support professionals who work directly with the member served in Residential, Employment, or Day Program services.
  - 2. A person qualified to address the health and medical needs of a member who is medically involved. The Support Coordinator and District/Division nurse will determine which Division staff or providers meet this qualification.
  - 3. Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID)
    - i. A Qualified Intellectual Disabilities Professional (QIDP), who typically is the Division Support Coordinator.

- ii. The member's primary care provider (PCP), who may participate by means of written reports, evaluations, and recommendations.
  - iii. The Division/District nurse assigned to the facility.
  - iv. Therapists when there is an indication of need and/or where services are currently being provided.
  - v. Providers of direct service in other programs received or needed by the member, such as adult day, child day, or educational programs.
4. Nursing Facilities (NF):
- i. The member's primary care provider (PCP), who may participate by means of written reports, evaluations, and recommendations.
  - ii. The Division/District Nurse assigned to the NF.
  - iii. Therapists when there is an indication of need and/or where services are currently provided.
  - iv. Staff from NF.
  - v. The member's primary caregiver(s).

A.R.S. § 36.551.01

[azleg.gov/ArizonaRevisedStatutes.asp](http://azleg.gov/ArizonaRevisedStatutes.asp)

A.A.C. R6-6-101

[azsos.gov/public\\_services/rules.htm](http://azsos.gov/public_services/rules.htm)

## **404 Planning Meetings**

### Member Attendance

The member must be present at all planning meetings unless the responsible person has requested the member not attend. When this occurs, the Support Coordinator must complete a face-to-face visit with the member by the required planning meeting due date and document the reason the responsible person requested the member not attend the planning meeting.

### Initial Planning Meeting (Newly Eligible)

The timeframe requirements for the initial planning meeting are based on the date the Division is notified of the member's eligibility. All initial planning meetings must be completed following the timeframes below.

#### A. ALTCS (LTC)

The Support Coordinator will:

- 1. Contact the responsible person within five days of Focus eligibility notification to schedule the meeting.
- 2. Hold the planning meeting in person within ten days of Focus eligibility notification.

3. Complete the following documents as appropriate:
  - i. The ALTCS ISP Packet, when Targeted/DD Annual Plan has already been completed.
  - ii. The Reassessment of the Planning Document and Service Evaluation, when ALTCS ISP Packet has already been completed.
  - iii. The ALTCS ISP Packet when the member is Newly DD eligible and became ALTCS eligible prior to initial meeting.
  - iv. Any other required paperwork.
- B. Targeted Support Coordination (TSC)

The Support Coordinator will:

  1. Contact the responsible person within five days of Focus eligibility notification to schedule the Targeted Planning Meeting.
  2. Hold the Targeted Planning Meeting in person within ten days of Focus eligibility notification.
    - i. When the member is newly TSC eligible, and the other scenarios do not apply complete Targeted/DD Annual Plan.
    - ii. When Targeted/DD Annual Plan has already been completed and the next scheduled planning meeting is due, complete Reassessment of the Planning Document. When the next planning meeting is not due, complete a narrative of the Targeted Planning Meeting and file with the Targeted/DD Annual Plan.
    - iii. When ALTCS ISP Packet has already been completed, and the member becomes eligible for TSC, and the next scheduled planning meeting is not due within the initial 10-day timeframe, complete a narrative of the planning meeting and file with the ALTCS ISP Packet.
    - iv. Complete any other required paperwork, as appropriate.
- C. DD Only (DDD)

The Support Coordinator will:

  1. Contact the responsible person within ten days of Focus eligibility notification to schedule the meeting.

2. Hold the planning meeting in person within 30 days of Focus eligibility notification.
3. Complete the Annual Plan for Targeted/DD Only.

### Subsequent Planning Meetings

The Support Coordinator will complete all subsequent Planning Meetings following the timeframes below.

#### A. ALTCS (LTC)

1. Acute Care Only (No long-term care services.)

The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.
- ii. Complete the Reassessment/ ISP Update Packet, as appropriate.
- iii. Complete any other required paperwork, as appropriate.

2. Home and Community Based Services (HCBS)

The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.
- ii. Complete the Reassessment/ ISP Update Packet, as appropriate.
- iii. Complete any other required paperwork, as appropriate.

3. Child/Adult Developmental Home - regardless of age

The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.
- ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
- iii. Complete any other required paperwork, as appropriate.

4. Group Home – age 12 and under

The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.

- ii. Complete the Reassessment / Residential ISP Update Packet, as appropriate.
    - iii. Complete any other required paperwork, as appropriate.
  5. Group Home – over age 12, no RBHA involvement  
The Support Coordinator will:
    - i. Hold meetings every 180 days after initial/annual meeting.
    - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
    - iii. Complete any other required paperwork, as appropriate.
  6. Group Home – over age 12, RBHA involvement  
The Support Coordinator will:
    - i. Hold meetings every 90 days after the initial/annual meeting.
    - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
    - iii. Complete any other required paperwork, as appropriate.
  7. Group Home – over age 12, medically involved  
The Support Coordinator will:
    - i. Hold meetings every 90 days after the initial/annual meeting.
    - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
    - iii. Complete any other required paperwork, as appropriate.
  8. Nursing Facility or Intermediate Care Facility  
The Support Coordinator will:
    - i. Hold meetings every 180 days after the initial/annual meeting.
    - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
    - iii. Complete any other required paperwork, as appropriate.

9. Assisted Living Centers

The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.
- ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
- iii. Complete any other required paperwork, as appropriate.

10. Foster Care

The Support Coordinator will:

- i. Hold meetings as required by the member's placement and eligibility.
- ii. Complete required paperwork as required by the member's placement and eligibility.
- iii. Complete any other required paperwork, as appropriate.

11. Member starts a new day or employment program:  
Within 30 calendar days of starting new program.

12. Member moves from one placement type to a different placement type: Within 10 business days of the move.

13. Member moves from a placement type to the same placement type: Within 30 calendar days of the move.

Targeted (TSC)

1. All TSC members.

The Support Coordinator will:

- i. Hold face-to-face meetings every 90 days (two visits) for the first six months after initial eligibility.
- ii. Ask the member/responsible person the preference for type and frequency of ongoing meetings at the second 90-day review.

2. No Long Term Care Services

The Support Coordinator will contact the responsible person by the type and frequency of contact requested:

- i. In-Person Contact

The Support Coordinator will:

- a. Complete the Annual Plan – Targeted/DD Only or Reassessment, as appropriate.
    - b. Complete any other required paperwork, as appropriate.
  - ii. Letter Contact  
The Support Coordinator will:
    - a. Send a letter to the member/responsible person that is appropriate to the member’s needs/circumstances. The letter may contain:  
  
Follow up questions based on previous meetings.  
  
Questions about any changes since the member’s last meeting, such as contact information and member’s needs.
    - b. Mail the letter by regular and registered mail, return receipt requested.
    - c. Update the review/ISP date in Focus with the date the letter was mailed.
  - iii. Phone Contact  
The Support Coordinator will:
    - a. Complete the Annual Plan – Targeted/DD Only or Reassessment
    - b. Mail completed paperwork to member/responsible person for signature within 15 working days of the phone call.
    - c. Update the review/ISP date in Focus with the date of the phone call.
3. Home and Community Based Services (HCBS)  
The Support Coordinator will:
  - i. Hold meetings every 90 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
4. Child/Adult Developmental Home - regardless of age

The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.
- ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
- iii. Complete any other required paperwork, as appropriate.

5. Group Home – age 12 and under

The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.
- ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
- iii. Complete any other required paperwork, as appropriate.

6. Group Home – over age 12, no RBHA involvement

The Support Coordinator will:

- i. Hold meetings every 180 days after the initial/annual meeting.
- ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
- iii. Complete any other required paperwork, as appropriate.

7. Group Home – over age 12, RBHA involvement

The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.
- ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
- iii. Complete any other required paperwork, as appropriate.

8. Group Home – over age 12, medically involved

The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.

- ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
- 9. Nursing Facility or Intermediate Care Facility  
The Support Coordinator will:
  - i. Hold meetings every 180 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
- 10. Assisted Living Centers  
The Support Coordinator will:
  - i. Hold meetings every 90 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
- 11. Foster care  
The Support Coordinator will:
  - i. Hold meetings as required by the member's placement and eligibility.
  - ii. Complete required paperwork as required by the member's placement and eligibility.
  - iii. Complete any other required paperwork, as appropriate.
- 12. Member starts a new day or employment program:  
Within 30 calendar days of starting new program.
- 13. Member moves from one placement type to a different placement type: Within 10 business days of the move.
- 14. Member moves from a placement type to the same placement type: Within 30 calendar days of the move.

DD Only (DDD)

- 1. No Long Term Care services:

The Support Coordinator will:

- i. Ask the member/responsible person the contact preference for ongoing meetings after one year of eligibility (two face to face 180-day meetings)
- ii. Hold type of preferred meeting at least annually after one year of eligibility
- iii. The Support Coordinator will contact the responsible person by the type of contact requested:

- a. In-Person Contact

The Support Coordinator will:

Complete the Annual Plan – Targeted/DD Only or Reassessment, as appropriate.

Complete any other required paperwork, as appropriate.

- b. Letter Contact

The Support Coordinator will:

- Send a letter to the member/responsible person that is appropriate to the member’s needs/circumstances. The letter may include:
- Follow up questions from previous meetings.
- Any changes since last meeting?
- Any changes to contact information?
- Mail the letter by regular and registered mail, return receipt requested.
- Update the review/ISP date in Focus with the date the letter is mailed.

- c. By Phone Contact

The Support Coordinator will:

- Complete the Annual Plan – Targeted/DD Only or Reassessment.
- Mail completed paperwork to member/responsible person for

- signature within 15 working days of the phone call.
    - Update the review/ISP date in Focus with the date of the phone call.
  - iv. After the first year of eligibility (two face to face 180 day reviews) a file review will be completed 180 days after the annual. The file review is not completed based on the contact preference; however, a phone call may be required to obtain information. A file review shall consist of a review of the Annual Plan and:
    - Re-determination of eligibility.
    - Updating Focus with the date of the file review and any other relevant information.
      - Obtaining school records, if school age.
    - Referrals to community resources.
    - Documentation that the file review was completed.
- 2. Home and Community Based Services (HCBS)  
The Support Coordinator will:
  - i. Hold meetings every 90 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
- 3. Child/Adult Developmental Home - regardless of age  
The Support Coordinator will:
  - i. Hold meetings every 90 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
- 4. Group Home – age 12 and under  
The Support Coordinator will:

- i. Hold meetings every 90 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
5. Group Home – over age 12, no RBHA involvement  
The Support Coordinator will:
  - i. Hold meetings every 180 days after initial/annual meeting.
  - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
6. Group Home – over age 12, RBHA involvement  
The Support Coordinator will:
  - i. Hold meetings every 90 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
7. Group Home – over age 12, medically involved  
The Support Coordinator will:
  - i. Hold meetings every 90 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
8. Nursing Facility or Intermediate Care Facility  
The Support Coordinator will:
  - i. Hold meetings every 180 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.

- iii. Complete any other required paperwork, as appropriate.
9. Assisted Living Centers  
The Support Coordinator will:
  - i. Hold meetings every 90 days after the initial/annual meeting.
  - ii. Complete the Reassessment/ Residential ISP Update Packet, as appropriate.
  - iii. Complete any other required paperwork, as appropriate.
10. Foster care  
The Support Coordinator will:
  - i. Hold meetings as required by the member's placement and eligibility.
  - ii. Complete required paperwork as required by the member's placement and eligibility.
  - iii. Complete any other required paperwork, as appropriate.
11. Member starts a new day or employment program: Within 30 calendar days of starting new program.
12. Member moves from one placement type to a different placement type: Within 10 business days of the move.
13. Member moves from a placement type to the same placement type: Within 30 calendar days of the move.
14. Inactive Status: The Support Coordinator will contact the member/responsible person annually by phone.

#### Scheduling Subsequent Meetings

With the exception of the initial planning meeting, subsequent meetings shall be scheduled and written notice given at the end of each planning meeting. The date and time of the meetings should be at the convenience of the responsible person. In addition, the Support Coordinator shall provide the team members written notice of upcoming annual planning meetings at least 10 days in advance. The Support Coordinator shall document all attempts to schedule planning meetings at the required or requested TSC intervals. The Support Coordinator shall document the reason in the progress note when the responsible person delays, cancels, or reschedules the meeting.

### Focus ISP Date (Set in stone date)

The meeting date on which the initial plan was developed becomes the Focus ISP date. The annual planning meeting may be held up to 5 working days before the Focus ISP date every subsequent year. An annual meeting held more than five working days prior to the Focus ISP date is considered a review meeting, not the annual planning meeting. Review meetings may be held at any time prior to their due date. All planning meeting due dates are based on the mandated review cycle.

### Meeting Location

(Reference: [Arizona Health Care Cost Containment System Medical Policy Manual \[AMPM\] Chapter 1620 - E](#))

In order for the Support Coordinator to assess the living environment to evaluate potential barriers to quality care, all planning meetings must be conducted at the member's residence. The Support Coordinator may also visit any setting where the member receives services.

If the responsible person requests an alternate site for the planning meeting, the Support Coordinator must document the request and the reason in the progress notes. Planning meetings at an alternative site should be the exception, and should not be at the convenience of the Support Coordinator or provider. If the planning meeting occurs at an alternate site, the Support Coordinator must visit the member's residence and the member must be present for this visit. Both the planning meeting and the visit to the member's residence must occur prior to the planning meeting due date.

### Special Meetings

The Planning Team may meet to review and revise the Planning Document at any time when there is change. The planning team must reconvene in the following circumstances:

- A. When there is a change in the member's medical treatment or physical condition that significantly affects daily living and is not of a short term or emergency nature.
- B. Prior to any transfer to/from a residential setting operated or funded by the Division.
- C. When there is a change that affects the continued implementation of the planning document.
- D. When the results of a grievance/appeals process require a review and/or revision of the current Planning Document.
- E. For members living in a licensed residential setting, when an emergency measure, including a one-time emergency use of behavior modifying medication ordered by a Doctor, is used to

manage a behavior two or more times in a 30 day period or with any identifiable pattern, or when required by the results of Program Review Committee (PRC) or Human Rights Committee (HRC) reviews of behavior plans.

### Mandatory Reporting

A. Abuse/Neglect

If, during the course of a Plan Review or any other contact with the member the Support Coordinator identifies any instance of abuse or neglect, she/he is required, by law, to report this to a police officer or protective services worker.

B. Quality Assurance

Support Coordinators may become aware of quality assurance issues during the course of their work, e.g., residential licensing standards that are out of compliance; inappropriate implementation of individual programs; untimely medical check-ups; or serious incidents not have not being reported. The Support Coordinator must verbally report problems to provider relations or quality assurance staff.

## **405 Coordination of Care**

### Acute Medical Care

The Support Coordinator along with Health Care Services (HCS) ensures coordination of care for each member. Each subcontracted health plan has an identified liaison to assist with the coordination of care for Division members enrolled through the Arizona Long Term Care System (ALTCS) program.

The Support Coordinator will:

- A. Contact the health plan liaison when a member has a concern related to medical services received or needed from the subcontracted health plan.
- B. Contact HCS when there are issues that cannot be resolved with the liaisons.

### Children's Rehabilitative Services (CRS)

The Support Coordinator along with Health Care Services (HCS) ensures coordination of care for each member receiving medical and behavioral health services from CRS.

The Support Coordinator will:

- A. Contact the CRS liaison when a member has a concern related to medical or behavioral health services received or needed from CRS.

- B. Contact HCS when there are issues that cannot be resolved with the liaison.

### Behavioral Health

When the Planning Document indicates a need for behavioral health services, the Support Coordinator shall initiate and coordinate such services with the Regional Behavioral Health Authority (RBHA). Additional information is available on the Arizona Division of Health Services/Division of Behavioral Health Services (ADHS/DBHS) website for each [RBHA Provider Manual](#).

- A. Qualified Behavioral Health Professional Consult (QBHP)

The Support Coordinator shall complete an initial consultation and quarterly consultations thereafter with the qualified behavioral health professional for all members receiving/needing behavioral health services. Quarterly consultations are not required for members who are stable on psychotropic medications and are not receiving any other behavioral health services.
- B. Behavioral Health Treatment Plan (From RBHA Provider)

The Behavioral Health Treatment Plan from the RBHA Provider becomes part of the Division's Planning Document. The Support Coordinator must include outcomes relevant to a Behavioral Health Treatment Plan on the Division's Planning Document.
- C. Child and Family Teams

The Child and Family Team (CFT) is a group of people that include, at a minimum, the child and the family, a behavioral health representative, the Support Coordinator, and any members important in the child's life who are identified and invited to participate by the child and family. The size, scope, and intensity of involvement of the team members are determined by the CFT outcomes, with oversight by the behavioral health representative.
- D. Community Collaborative Care Teams

Community Collaborative Care Teams collaborate and coordinate care for members eligible for ALTCS who demonstrate inappropriate sexual behavior and/or aggressive behavior, who have been unresponsive to traditional ALTCS and behavioral health services and who have a co-occurring behavioral health condition or physical health condition.

### Department of Child Safety (DCS)

The Support Coordinator is responsible for coordinating services with the DCS Case Manager when a child eligible for Division services is in the custody of DCS.

#### DES Vocational Rehabilitation

The Support Coordinator/Employment Specialist is responsible for submitting and coordinating referrals to DES Vocational Rehabilitation for employment related services.

#### Arizona Department of Education/ Local Education Agency

The Division shall coordinate services with the Arizona Department of Education Local Education Agency (LEA) under three distinct circumstances:

- A. When the Division makes an out-of-home placement for educational purposes (A.R.S. §15-765, [www.azleg.gov](http://www.azleg.gov)).
- B. When the Division makes an out-of-home placement of a member receiving public education for other than educational purposes.
- C. When a child receiving early intervention services (day treatment and training) from the Division reaches ages two years six months and two years nine months, in order to plan for preschool transition.

#### Coordination of Care Between The Division And The School System

In addition to the review and annual due dates for the Planning Documents, the Support Coordinator is responsible for ensuring the overall provision of care in coordination of care with other agencies for each member, including educational services. It is important that the Support Coordinators and Support Coordinator Supervisors understand the appropriate ways to coordinate care with a local school system.

It is also important to develop working relationships with the various school districts within the proximity of the Support Coordinator's assigned Division office. This includes identifying the appropriate teachers and the school hierarchy for addressing any issues that may arise. The development of these relationships before serious concerns occur will assist in resolving issues in a more collaborative and timely manner.

The Support Coordinator should work with the family to identify the dates and times for meeting with the school, and participate in the development of the Individual Educational Program (IEP). Coordinating the efforts of the education plan with the Division's Planning Documents can ensure these plans complement each other and provide better care for the member. If the family does not remember to invite the Division staff to the IEP meeting, the school representative should be invited to the Division's Planning Meeting.

When the Division identifies an educational need, the Support Coordinator will take the following steps:

- A. Discuss identified need with the family.
- B. Within 5 working days of obtaining the family's agreement, contact the local schoolteacher and/or principal to inquire about the identified educational need.
- C. Contact the District Program Administrator/District Program Manager within 2 working days of contacting the school to request support with their counterpart in the local school district if the teacher and/or principle have not responded.
- D. Contact the Division's Central Office within 2 weeks to request support in coordination with the Special Education Division of the Arizona Department of Education when there has not been a response from the local school district.
- E. As appropriate, raise the general issue(s) at the State Department of Education through Central Office.
- F. Follow up with the member or the representative regarding whether or not the need has been/was met.

#### School Based Claiming For Medicaid

The School Based Claiming Program through Arizona Health Care Cost Containment System (AHCCCS) covers both school-age children who are Medicaid Long Term Care eligible, and members supported by the Division's Targeted Support Coordination. The member must be at least 3 years of age but younger than 22 years of age, and have been determined by the school to be eligible for special education and related services. (See [AHCCCS Medical Policy Manual Chapter 700](#) for additional information.)

#### Preschool Transition

Refer to [Arizona Early Intervention Program \(AzEIP\)](#) for information regarding transitioning to preschool.

### **406 Planning Document**

Support Coordinators when completing a Planning Document shall use a person-centered approach, taking into consideration natural and community resources, acute care services, home and community based services, what is important to the member now (priorities) and in the future (vision), and:

- A. Provide information to assist members/responsible persons in making informed decisions and choices.
- B. Provide members with flexible and creative service delivery options.
- C. Provide service options that support the member's priorities and outcomes.
- D. Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on the member.
- E. Provide necessary information to providers about any changes in the member's functioning to assist the provider in planning, delivering and monitoring services.
- F. Review all professional evaluations.
- G. Assume responsibility for completion of all components of the planning document in conjunction with the team.
- H. Provide copies of the completed Planning Document to all team members and service providers within 15 working days of the date of the Planning Team meeting, and ensuring that copies of the Planning Document are available in all settings where the individual receives services.

A critical component of the person-centered approach is the assessment process. This process involves the member and their family as appropriate in the identification of support needs and includes their participation in decision-making. In designing the plan, the Planning Team must consider the unique characteristics of the member as expressed by the member or documented by others who know the member. For the member, the Planning Process will:

- A. Recognize and respect rights.
- B. Encourage independence.
- C. Recognize and value their competence and dignity.
- D. Promote social inclusion.
- E. Preserve integrity.
- F. Support strengths.
- G. Maintain the quality of life.
- H. Enhance all areas of development.
- I. Promote safety and economic security.

### Annual Plans

An Annual Plan is required for all members. The member's eligibility and placement determines the type of plan to be completed.

#### Reassessment of the Planning Document

Reassessments of the planning document are completed based on the member's eligibility and placement. The reassessment is a review of the annual plan.

#### Changes to the Planning Document

Any team member may recommend Changes in the Planning Document/ISP by forwarding the proposed change to the Support Coordinator using the Changes in the ISP form. Examples may include:

- A. New or changes to outcomes;
- B. New action items;
- C. Changes in medications;
- D. Changes to the spending plan.

The Support Coordinator shall sign the Changes in the ISP signifying that the recommended change does not require a Planning Team meeting as outlined in this policy manual, obtain the member/responsible person's signature, file the original with the ISP/Planning Document in the member's file and forward a copy of the form to each team member. Any team member who disagrees with the change may request a special team meeting.

#### Attendance Sheet

The Attendance Sheet is required at every planning meeting to record who was present. Signatures are required from all team members. If a team member refuses to sign or is unable to sign, the Support Coordinator will print their name and indicate they were present. Signing the Attendance Sheet does not indicate agreement or disagreement with the planning document.

#### Acknowledgement of Publications/Information

Acknowledgement of Publications/Information highlights important information the Division is required to provide to members/responsible persons. Based on the member's eligibility the Support Coordinator shall provide or offer the following publications:

- A. Statement of Rights;
- B. Notice of Privacy Practices;
- C. ALTCS Member Handbook (For ALTCS members);
- D. Decisions About Your Healthcare (For members age 18 and older);
- E. Voter Registration (For members who do not have a legal guardian and who are or will be 18 by the next general election).

Additionally there are acknowledgements the member/responsible person shall make when reviewing this form. This form is reviewed at the initial planning meeting and annually thereafter and signed by the member/responsible person.

#### Team Assessment Summary/Working With Me

The Team Assessment Summary captures a complete picture of the member's capacities, resources, challenges, and supports needed. The Support Coordinator obtains this information through a discussion with the team at the annual planning meeting.

#### Support Information

The Support Information page captures adaptive equipment, behavioral health information and medications for members. Advance directive and burial plans information is captured on this page for members age 18 and older.

#### Risk Assessment Plan

**Every** member enrolled in the Division must be assessed for potential risks. The Risk Assessment identifies behaviors or conditions that may compromise the member's health, safety, well-being, or quality of life. The Planning Team shall develop steps to minimize or eliminate the potential risks. The emphasis on prevention shall not result in disregard of rights, preferences or lifestyle choices. Age appropriate developmental skills shall be taken into consideration for infants and children when assessing potential risks. The Risk Assessment is reviewed at every planning and revised as needed.

#### Vision and Priorities

The member's Vision and Priorities page provides direction for the plan. The Vision identifies the desired future for the member. The Priorities are what the member/responsible person would like to focus on in the upcoming year to help members reach their Vision.

#### Service Considerations/Evaluation

The Service Considerations page assists the team in evaluating the appropriate services a member may need. The Service Evaluation documents a member's abilities and current and future support needs. Outcomes identified for members assessed for Habilitation Hourly are also documented on this form. Services other than Habilitation Hourly are documented on the Additional Service Outcome page.

#### Service Outcomes

Based on the person's Vision and Priorities, the Support Coordinator facilitates the development of attainable, observable, measurable and time-limited outcomes. Members who receive habilitation, day treatment, and training, employment related programs, behavioral health supports, or therapy shall have outcomes identified on the planning document. If progress on an outcome is not made

within the designated timeframe, the team shall consider changing the teaching strategy; developing a new outcome; offering a different service; or stopping the service.

The selected provider shall write a strategy for each outcome, which describes the methodology to be used to support the member to achieve the outcome. The strategy shall identify the time needed to implement the methodology described and define the data to be recorded regarding progress. Support Coordinators are responsible for ensuring continuity of teaching strategies related to outcomes that occur in more than one setting.

### Service Plan

The Service Plan documents the assessed services to be authorized, other services requested by team members, and/or indirect services. A Service Plan is completed at every meeting for all members eligible for the Division, excluding children who are Non-ALTCS AzEIP eligible.

### Contingency Plan (Back-up Plans)

Development of the Contingency Plan (Back-Up Plan) is required when any of the following critical services are authorized:

- A. Attendant Care;
- B. Homemaker;
- C. Respite;
- D. Habilitation –Individually Designed Living Arrangement.
- E. Nursing

Contingency plans ensure continuous provision of services when the direct care worker is unable to work when scheduled. Family members should not be considered as a substitute for a back-up plan. The agency authorized must offer a substitute direct care worker. The member/family may decline a substitute direct care worker and not receive the critical service from an agency direct care worker or may elect to provide the service informally.

When only independent providers are authorized to provide services, the planning team must consider an agency as a backup. The backup plan should include the back-up person identified and a reasonable option for alternative supports. Multiple back-ups must also be identified.

The Back-Up Plan *requires* a member to select and document their preference level. The preference level is the time a critical service needs to be provided when the scheduled provider is unable to work a scheduled shift. The preference level may be changed by the responsible person at any time.

The Back-Up Plan is completed annually and reviewed at each meeting.

### Action Items

Each Planning Document includes action items to be completed, the person responsible for completing each action item, and the date by which the action item must be completed. This form is completed annually and reviewed at each planning meeting.

### Summary of Professional Evaluations

The Summary of Professional Evaluations captures medical appointments and medical issues. This form is required annually for members who live licensed residential settings.

### Rights, Health and Safeguards

The Rights, Health and Safeguards form documents exceptions to residential licensing. This form is required annually for all members residing in licensed residential settings.

### Spending Plan

The Spending Plan determines how the member's money will be spent in the upcoming year. The form is required annually for all members for whom the Division is the representative payee and for all members living in licensed residential settings.

### Transfer Plan

Prior to transfer of a non-medically involved member from a residential setting operated or financially supported by the Division, the Planning Team must meet to plan the transfer. The Transfer Plan will be documented on the Residential Transfer Checklist.

### Cost Effectiveness Studies (CES)

Home and Community Based Services (HCBS) provided under the Arizona Long Term Care System (ALTCBS) must be cost-effective when compared to the cost of an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID). It is the responsibility of the Planning Team to identify if the member's costs will exceed 100% of the ICF/IID rate, and develop a plan to reduce Long Term Care costs. Written Cost Effectiveness Studies (CES) are also required by AHCCCS for Long Term Care eligible persons whose costs exceed 80% of the ICF/IID rate.

The CES is a three-month projection of costs. The Support Coordinator must complete a CES if the member's name appears on the quarterly report "Client\_0060 – Members Exceeding 80% Cost Effectiveness." This report identifies members whose costs exceeded 80% of the institutional rate in previous quarters. When the Support Coordinator identifies the need for a CES, it should be submitted to the Long Term Care Specialist within thirty (30) days. A

copy is maintained in the member's file. Collaboration should take place with identified District staff to obtain information. Completion of a *Cost Effectiveness Study Worksheet* must be done quarterly until costs are reduced below 80%.

In addition, a CES is required within 30 calendar days for the following services:

- A. Nursing services (including nursing respite) in excess of 200 hours monthly;
- B. Residential Habilitation – Medical Group Home;
- C. Concurrent services of Residential Habilitation (Individually Designed Living Arrangement or Group Home) when the staff ratio is 1:1 or 1:2 at either program;
- D. Habilitation community protection.

The Division receives a monthly report (CATS) from the Arizona Health Care Cost Containment System (AHCCCS) identifying members who had previously been above 80% of the institutional cost. For these members who are now below 80%, a new CES must be completed and entered on the CA160 screen in the AHCCCS computer system within sixty (60) days of the report.

Each CES must be signed by the Support Coordinator Supervisor (for those below 100%) or the District Program Manager/Administrator (for those above 100%). This signature assures that all appropriate CES policies and procedures have been followed.

When a member is discharged from an institutional placement (e.g., an ICF/IID, the Arizona State Hospital, a Skilled Nursing Facility) the Support Coordinator must complete a CES prior to the move. The costs used for the study should be those proposed for the new placement, not from the institutional placement.

The completed CES will be reviewed by District placement personnel. If the costs are below 100% of the appropriate institutional level and the move is approved, copies will be sent to ALTCS Specialists and maintained in the member's case record. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system at CA160.

In addition to the CES, a discharge plan consistent with Division policy must be in place prior to any move.

**Note:** it is advisable to complete an analysis of costs prior to any and all placement changes (group home, developmental home, etc.).

The completed CES and the cost reduction plan must be maintained in the member's case record. A copy of the CES shall be submitted to the ALTCS Specialist. The ALTCS Specialist will ensure that the CES is entered in the AHCCCS computer system.

Until the CES is brought below 80%, the Support Coordinator will be required to complete and submit a *Cost Effectiveness Worksheet* quarterly. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system.

When the completed CES generates a result over 100%, member the following options should be pursued:

- A. Request a higher medical rate;
- B. Request a higher behavioral health rate; or,
- C. Reconvene the Planning Team to review services.

#### Request A Higher Medical Rate Through The Health Care Services (HCS) Office

The Support Coordinator submits documentation for the HCS to review the appropriate use of a higher medical institutional rate. The Support Coordinator must complete a justification packet that includes the following information:

- A. Narrative describing the member's current status and need. This narrative should address the member's diagnosis, medical and/or behavioral conditions, current living arrangement, provider or family care schedule and any other helpful information
- B. Current nursing assessment
- C. Plan to reduce costs
- D. Current CES
- E. Any other information that will assist HCS staff in evaluating the request
- F. Current Planning Document

#### Request A Higher Behavioral Health Rate Through The Behavioral Health Unit

Support Coordinators and ALTCS Specialists submit documentation for the Behavioral Health Unit to review the appropriate use of a higher behavioral health institutional rate. The Support Coordinators and ALTCS Specialists must complete a justification packet that includes the following:

- A. Narrative describing how the person meets the criteria.
- B. Current CES Worksheet
- C. Plan To Reduce Costs

Health Care Services or the Behavioral Health Unit will inform the ALTCS Specialist of authorizations for higher institutional rates (medical and/or behavioral) with the approval time period. If costs continue at the higher level, a request should be resubmitted in advance of the approval expiration. Should the approval expire or be denied, the institutional rate will revert back to the regular

institutional rate. The Support Coordinator must initiate review of the other remaining options listed above.

#### Procedures for Reducing Cost Below 100% within 6 months

The AHCCCS Medical Policy Manual provides that when the cost is expected to be below 100% within the next six months, justification must be added to the CES and documented in the case file.

When/If services are reduced; the Support Coordinator must follow the Member Rights and Responsibilities Notification procedure, described in Chapter 1500. If it is unlikely that costs can or will be reduced in the next six-month period, the Support Coordinator is responsible for initiating a review of other options.

Once the Support Coordinator completes the CES and costs are found to exceed 100%, the Support Coordinator must submit the calculation to the District ALTCS Specialist so it can be entered in the AHCCCS computer system at CA160. In addition, the Support Coordinator should immediately consult with their supervisor, area manager, nurse, contract staff, etc. The Support Coordinator may need to call special team meetings to address the high costs. Planning Team members, including providers, should be notified that current costs exceed institutional levels and overall costs must be reduced by the end of the six-month period. The Planning Team may discuss the following:

- A. Reducing service units (reducing staffing levels)
- B. Alternative placements

If, at the end of six months, costs have not been reduced below 100%, the Support Coordinator must notify the ALTCS Specialist, the DPM/DPA, and the ALTCS Program Administrator.

If the DPM/DPA approves services above the 100% CES threshold, these costs must be paid with state funds. The Support Coordinator will advise the CES Manager/Business Operations to adjust payments accordingly. The revised CES (below 100%) is filed in the case record, and a copy is submitted to the ALTCS Specialist. The CES calculation previously entered in the AHCCCS computer system at CA160 will be adjusted to reflect Medicaid approved costs up to but not exceeding 100% of institutional cost.

State funds may be available for members residing in licensed residential settings such as group homes, child developmental or adult developmental homes.

Approval of this option to use state funds is contingent upon the Division offering the member/responsible person an alternative placement in a more cost effective setting, and the member and/or responsible person refusing that offer.

If District administration denies the use of state funds, the Support Coordinator should initiate termination of service costs in excess of 100%. The Support

Coordinator must advise the member/responsible person of the cost effectiveness limitations and discuss other options. The Support Coordinator must also follow the Member Rights and Responsibilities Notification procedures.

If the member chooses to remain in his/her current placement, even though the Division cannot provide all of the services that have been assessed as medically necessary (including those ordered by the member's Primary Care Provider), a *Managed Risk Agreement* is completed. This agreement should document:

- A. The amount and type of service the Division can provide cost effectively,
- B. The placement/service options offered to the member,
- C. The member's choices regarding those options,
- D. The risks associated with the decrease in service amounts and
- E. Any plans the member/responsible person has to address those risks (i.e., paying privately for services above 100%, using volunteer services.)

The member/responsible person acknowledge and agree the service limitations and risks by signing the *Managed Risk Agreement*.

#### Considerations for Possible Institutional Placement

When considering institutional placement, the Support Coordinator must first document all other options considered and reasons why these options were not chosen, and submit for review by the District Program Administrator/Manager. The Planning Team must discuss the lack of appropriate, cost effective alternatives for the member and discuss the potential placement.

The Support Coordinator will submit a completed *Cost Effectiveness Study Worksheet* to the ALTCS Specialist. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system.

District administration may continue current costs while any of the above options are being pursued. After six months, if costs continue beyond 100% without AHCCCS approval, the CES calculation in the AHCCCS system must be adjusted to reflect AHCCCS approved costs up to but not exceeding 100% of institutional cost.

#### **407 Service Authorization**

All services funded by the Division require authorization prior to delivery. Support Coordinators may authorize services in certain circumstances. Some services may require authorization in addition to that of the Support Coordinator, such as physician prescribed services, which require prior authorization by Health Care

Services (HCS). Other services may require authorization by the Assistant Director or designee.

The specific authorization requirements for each service are indicated in the Service Provision Guidelines sections in Chapter 600.

Authorization by the Division Support Coordinator shall be documented by the Support Coordinator's signature on the service plan.

For members who are eligible for Arizona Long Term Care System (ALTCS), the Support Coordinator shall authorize long term care services only when the assessment and planning process outlined in this policy manual determines the services to be medically necessary, cost effective and federally reimbursable. Services are cost effective when the total cost does not exceed 100% of the cost of an Intermediate Care Facility for Persons with an Intellectual Disability (ICF/IID). Non-covered services and services provided to members who are not ALTCS-Long Term Care shall be authorized only when the same processes determine them to be developmentally necessary and cost effective and state funding is available.

Prior to authorization, the Support Coordinator shall ensure that other potential resources for meeting the identified needs have been explored and are either not available or not sufficient to meet the documented need for both Long Term Care services and non-Long Term Care services. The Support Coordinator shall also ensure that the service will be provided in accordance with the service definitions and parameters outlined for each service in this policy manual.

Support Coordinators shall follow the steps outlined below in authorizing services:

- A. Members who are eligible for ALTCS receive identified services within thirty (30) days of eligibility. The Focus system will be updated within 5 days of the team meeting, unless a Utilization Review is required.
- B. A Utilization Review is required for any new or increase in service including attendant care, respite, habilitation and day treatment and training. This Utilization Review process must be completed within 10 days.
- C. Entry of approvals in Focus shall be approved or denied following Support Coordinator authorization, other District management staff authorization if needed, and Health Care Services (HCS) authorization or other Division staff, if needed.
- D. Within five days of approval by the appropriate authority, the Support Coordinator ensures authorization information for the needed service, the amount of units, the start/end dates and the preferred provider are entered in Focus.

### Other Authorizations

Therapies require prior authorization through the District Administration and the Central Office. Home Health Aide, Home Health Nurse, Hospice and Respiratory Therapy services require prior authorization through Health Care Services. Home modifications require prior authorization through the Home Modification unit.

#### **408 Arizona Long Term Care (ALTCS) Non-Users**

The Support Coordinator shall offer the member/responsible person the option to voluntarily withdraw from ALTCS and seek services through an AHCCCS Acute Care Plan or through other programs when there is no assessed service need or no intent to pursue ALTCS services. If the individual voluntarily withdraws from ALTCS, the Support Coordinator shall inform the responsible person of the right to reapply for ALTCS at any time.

If the individual/responsible person chooses **not** to voluntarily withdraw from the ALTCS program, Acute Care status may be appropriate. The Division will notify the member/responsible person that a change from Long Term Care to Acute Care status is being requested and AHCCCS may contact them to complete a financial redetermination.

#### **409 Case Closure**

##### Causes for Division Case Closure

The following situations may require Division case closure. The member:

- A. no longer meets the eligibility requirements defined in this policy manual;
- B. requests case closure verbally, in writing or the responsible person requests such action;
- C. reaches the age of eighteen (unless an application for continuation of services has been filed);
- D. moved from previous residence and cannot be located via a certified letter, return receipt requested;
- E. moved out of state;
- F. has passed away.

All contact attempts must be documented in the case file. Prior to case closure the Support Coordinator/Supervisor shall ensure due diligence to make contact and determine why attempts were unsuccessful. Additionally, the following must be considered:

- A. *ALTCS eligibility* – These cases cannot be closed until the Division receives a roster disenrollment from AHCCCS.

- B. *Inactive Status* – An option to consider if the person has a history of being unable to contact.

If the Support Coordinator/Supervisor determines case closure will be necessary, this should occur within 30 calendar days. Any Focus authorizations must be ended when a case closure occurs.

Members who are eligible for the ALTCS cannot be placed in inactive status or discharged from the Division until the AHCCCS dis-enrolls them via a roster transmission. As long as the person remains ALTCS eligible, the Support Coordinator must continue attempts to schedule a meeting. AHCCCS will not dis-enroll the member if AHCCCS is able to contact with the member.

#### Notification of Case Closure

A *Notice of Service System Discharge* must be sent by certified mail, return receipt requested, to the member/responsible person informing him/her of the case closure at least 35 days prior to the date of the case closure. A copy shall also be sent to the local ALTCS office if the member is ALTCS eligible. The notice shall also discuss the opportunity for administrative review as described in Chapter 2200. If the member is ALTCS eligible, a case cannot be closed until AHCCCS dis-enrolls the member.

A *Notice of Service System Discharge* shall not be sent in instances where the member has passed away.

#### Documentation of Case Closure

The following steps shall be taken at the time a member's case is closed:

- A. Include a copy of the applicable *Notice of Service System Discharge* in the case record.
- B. Close the record in Focus including the appropriate reason code. If the member is ALTCS eligible, the case cannot be closed until AHCCCS dis-enrolls the member.
- C. Store the record in accordance with this policy manual.