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\*Note: See specific service sections on the Policy Notification for Effective Dates. Further revisions to services in this chapter will be noted as the Issue/Revision Date.

## **800 SPECIALITY SERVICES**

### **801 Overview**

This chapter describes specialty services provided by the Division based on assessed need. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) can help determine the service types and amounts of support a member may receive. The person with a disability may request the Planning Team to help them identify what their needs. It further provides a description of each service of the service provision, provider type and training required, service limitations and exclusions (non-Long Term Care Services covered services are available based upon the availability of state funds).

### **802 Augmentative Communication Devices**

#### Service Description and Goals

Augmentative communication devices are those devices that enhance a member's ability to communicate with others at his/her highest level of independence.

#### Service Settings

Augmentative communication devices are appropriate for use in all settings.

#### Service Requirements

The member and their Individual Support Plan/Individualized Family Services Plan/Person Centered (Planning Team) team must identify the need for an augmentative/alternative communication evaluation. This determination shall be made by using the Pre-Admission Screening (PAS) tool, the Inventory for Client and Agency Planning (ICAP) tool and any other available information to assess whether there may be a functional gap between the member's receptive and expressive language skills, and/or the member demonstrates communicative intent as determined by the Communicative Intent Checklist. The Support Coordinator must prepare a packet of information and forward it to Health Care Services in Central Office within 15 working days of the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meeting (Planning Meeting). The packet must include all of the following:

- A. The completed Augmentative Communication Referral Checklist.
- B. The current Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) that includes long-term communication goals.

- C. A prescription for the augmentative/alternative communication evaluation and equipment as needed dated within the past 12 months.
- D. A speech and language evaluation dated within the past 12 months.
- E. The current Individualized Education Plan (IEP) if school age.
- F. Documentation of previous use of low technology devices such as picture boards or dial scanners.
- G. Occupational therapy evaluation dated within the past 12 months if the member has fine/sensory motor problems that may impact the ability to touch a small target square, to push hard enough to operate a switch or if there are limitations in the member range of motion or head control.
- H. Physical therapy evaluation dated within the past 12 months if the member has seating, positioning, and/or mobility needs related to augmentative/alternative communication device use.
- I. Formal or functional hearing test within the past 12 months.
- J. Formal or functional vision test within the past 12 months.
- K. Therapy progress reports, if therapy has been provided during the past 12 months.
- L. Third-party liability (TPL) insurance information.
- M. Any previous or current augmentative communication evaluation reports, if available.
- N. Any other reports relating to the acquisition of the skills and/or abilities necessary to operate an augmentative/alternative communication device, if available, e.g., a current psychological/psycho-educational evaluation, wheelchair/seating clinic evaluations.

An evaluation conducted by the school system is acceptable for school age members.

Health Care Services will either refer for further evaluation or order the device, as appropriate within 15 working days of receipt of the complete packet. Further evaluations may include referral to the contracted Augmentative/Alternative Communication Evaluation Team, Rehabilitation Engineering for access assessment or medical review.

Once the device is obtained, it will be sent to the Support Coordinator. The Support Coordinator delivers the device and obtains the responsible person's signature on the Acknowledgment of Receipt of Durable Medical Equipment form. This form is to be retained in the member's case record, with a copy sent to Health Care Services. Training on the use of the device will be arranged per case.

### Target Population

Members who are potentially eligible for communication systems are those who show communicative intent but whose expressive skills are currently below their receptive language skills and are not adequately meeting their day to day functional communication needs. For example, members may attempt to communicate through non-verbal approaches such as pointing, gesturing, signing, vocalizing sounds or eye gazing. Receptive language refers to understanding of spoken language, while expressive language refers to language output (traditionally speech). Such members may be candidates for an intervention strategy that includes the use of alternative forms of expressive communication. For such a strategy to be effective, other factors must be considered to ultimately guarantee benefit to the member, e.g., the long term goal, appropriate outcomes, valuation methods, mode of learning, follow up training and overall quality of life.

### Exclusions

Augmentative communication devices will not be provided under the following circumstances:

- A. The member has received appropriate teaching and therapeutic strategies and the prognosis for developing effective oral communication is poor.
- B. The member does not demonstrate the ability to make choices independently.
- C. The member will use the device solely in an educational setting.
- D. The member has used light/high technology communication systems and has not demonstrated the intent to communicate.
- E. The member has a history of destructive behavior and a plan of intervention has not been identified.
- F. The Planning Team outcomes and goals do not indicate a commitment to use the device in all settings.

### Service Provision Guidelines

The following service provision guidelines apply to augmentative/alternative communication devices:

- A. Devices will not be provided if not medically necessary and prescribed by the Primary Care Provider (PCP).
- B. One (1) device and the medically necessary accessories for operation will be provided.
- C. Only one (1) option will be provided (other options must be furnished by an alternative resource) if a device can be equipped with both voice and print capabilities.
- D. One (1) mount will be provided unless a second is medically necessary.
- E. Children under the age of 3 (who are referred as possible candidates for a device) will have their needs reviewed on a member basis. Toys are not a covered item.
- F. Replacement of equipment is covered in the following situations:
  - 1. Loss or irreparable damage or wear not caused by carelessness or abuse.
  - 2. Equipment replacement is recommended by an authorized re-evaluation. Re-evaluations for the purpose of upgrading the device will not be authorized for 6 months after the receipt of the current device.

Re-evaluations may be obtained if the current device is not meeting the member's needs despite adequate training of at least 3 months, there is a change in the member's medical condition, or communication goals were met or exceeded with the current system. Re-evaluations must include the same requirements as noted in Section 604.7.3 of this Chapter.

### Evaluation

The Support Coordinator must perform a review of the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) as noted in this Policy Manual.

### Service Closure

All devices and accessories will be returned to the Division when no longer medically necessary as determined by the Individual Support Plan, Individualized Family Services Plan or Person Centered Plan (Planning Documents). The device and accessories must be returned to the Division if the member is moving out of state. The Support Coordinator is responsible for picking up the device and accessories and returning them to Health Care Services. Health Care Services will then arrange for the device to be refurbished and reused.

## **803 Member and Family Assistance**

Member and Family Assistance is flexible support funding intended to enable families to care for children at home and for adult members to live independently in their communities. Member and Family Assistance is based on available funding and is not intended to replace natural or other means of support and assistance. They may be Emergency Support or Ongoing Support as described below.

### General Guidelines

All payments from these funds must be made to a vendor, not the family or member unless extenuating circumstances prevent it. For instance, in the case of rent subsidy payable to a family member who is renting to a member All exceptions must be prior approved in writing by the District Program Administrator) Services that may be purchased with Member and Family Assistance funds include those listed in the Arizona Taxonomy of Services, as well as financial assistance for specific purposes. These services may include:

- A. Automotive repairs (if the vehicle is unable to be driven and would put the member at risk if not repaired)
- B. Clothing
- C. Corrective lenses
- D. Dental needs
- E. Diapers
- F. Equipment repairs
- G. Medication
- H. Moving expenses

- I. Rent and/or living subsidy
- J. Transportation
- K. Utilities

Payments may produce a Federal Income Tax form 1099 that is sent to the recipient of these funds.

### Receipts

Receipts must be obtained for all purchases/payments with few exceptions. Exceptions may include ongoing rent so long as an annual rental agreement is on file, showing monthly rent with beginning and end dates. Receipts may also be submitted in the form of a bill or invoice in the case of utility bills or monthly service fees. Receipts are to include the following information:

- A. Vendor name/place of business
- B. Date of purchase
- C. Description of item(s) purchased
- D. Name of Member
- E. Name of Support Coordinator

All disbursements from Member and Family Assistance funds shall be documented as expended by submission of the original itemized receipt(s) within thirty days. No further funds shall be granted to the vendor until the receipts are submitted, unless approved by the District Program Administrator/Manager or in case of health and safety concerns.

The funds may only be spent for the approved purchase and not for any other items. If there are any excess funds, they are to be returned to the Division.

### Emergency Support

Emergency Support provides a one-time payment in emergent or extraordinary circumstances to eligible families on behalf of a member with a developmental disability living in the family home, or (for an adult) in either the family or her/his own home or in rare cases for a member living in a vendor operated setting with prior written approval by the District Program Administrator/Manager for health and safety purposes.

One-time payment amounts typically should not exceed \$500 per member or family. Any amounts over \$300 require District Program Manager/Administrator approval.

### Eligible Services

Only authorized services may be purchased with Member and Family Assistance funds. Authorized services are those recommended by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Team) and approved by the District Program Administrator/District Program Manager or designee. The Division will only approve services that can be purchased at a reasonable cost.

Emergency Support cannot be used to supplement the level of services already furnished to the family or member under Division contracts with service providers.

Emergency Support cannot be used to purchase services otherwise readily available to the family or members who are eligible for Long Term Care Services. Emergency Support is not available for Licensed Child Developmental or Adult Developmental Homes unless for health or safety matters not funded elsewhere. Members who have failed to take all reasonable steps to enroll in the Arizona Long Term Services program are not eligible for Emergency Support.

Other service options must be explored in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and, if appropriate, applications for alternative services or benefits may be made a condition of eligibility to receive Member and Family Assistance. These alternatives might include:

- A. Arizona Long Term Care Services;
- B. Income supplements such as Supplemental Security Income, Social Security Survivors Benefits, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Assistance to Needy Families, General Assistance and Emergency Assistance;
- C. Food stamps, Women, Infant and Children Program and food banks;
- D. Housing benefits available through Housing and Urban Development;
- E. Vocational Rehabilitation and the Job Training Partnership Act Program;
- F. Benefits rendered because of injury to persons or property;
- G. Education programs;

- H. Child support and adoption subsidies;
- I. Arizona Health Care Cost Containment System, Medicare, Indian Health Services and private health insurance;
- J. Supplemental Payments Program and benefits furnished under the Older Americans Act.

### Eligibility

All members/families must meet the following criteria to receive Emergency Support:

- A. Enrolled in the Division service system.
- B. Participation in the program by parent, other close relative, legal guardian or by the member. This participation usually takes the form of a co-payment for services.
- C. Require funds for health or safety concerns for which no other funding is available.

### Determination of Participation by Responsible Person

The Member and Family Assistance/Emergency Support funds are intended to form a partnership between families and the Division in meeting the needs of children or adults who live at home, or in independent or supported living arrangements not contracted as residential programs by the Division.

Emergency Support is "needs-based" and is not tied to a specific income eligibility level unlike the Arizona Long Term Care System. Families must demonstrate their co-pay participation related to cost for the service, item or other purchase to be eligible for Emergency Support.

In the case of an adult with a developmental disability living in her/his own home, the member must be able to demonstrate how much income is devoted to shelter and food before Member and Family Assistance/Emergency support payment can be approved. The member must also demonstrate how much income is devoted to an Individual Support Plan Team-approved program before an Emergency Support payment can be provided. The member's remaining resources are available for personal and incidental expenses. Members with more than \$3,000 in liquid assets (cash) are ineligible for Assistance to Families funds.

The Support Coordinator and member/responsible person shall complete the Member and Family Assistance Request Worksheet and Agreement when requesting participation in this program. The Planning Team shall review these documents and

forward them, with a recommendation, to the District Program Manager/District Program Administrator or designee. The packet must reflect the items or services funded by Emergency Support dollars, the type and amount of support, and the level of participation by the member or family.

### Guidelines for Approving Emergency Support

The District Program Manager/District Program Administrator (or designee) shall consider the following factors in evaluating requests for Emergency Support:

- A. Age and/or health status of the parents/family members.
- B. Complexity of the member's needs the stress that these place on the family, and the family's ability to respond to that stress.
- C. Degree of member or family participation in the cost of services relative to their means.
- D. Degree to which the member is already receiving other Division funded services.
- E. Availability of funding from all sources.
- F. Reason for the emergent or extraordinary request.

The District Program Manager/District Program Administrator should respond to a request for Emergency Support within five working days of the recommendation by the Planning Team.

### Payments

Services are authorized and participation/co-payments identified on the Member and Family Assistance Worksheet and Agreement. If approved, the payment will go directly to the vendor identified by the member or family.

### Waivers

The District Program Administrator/District Program Manager must approve any waivers for procedures or family participation. The waiver is only allowed if the goals and intent of the program are otherwise met.

The member, family or Support Coordinator is permitted to initiate a written request for a waiver. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan Team may also initiate a written waiver request. The request must identify the specific requirements to be waived. The District Program Administrator/District Program Manager will determine whether approval of the

requested waiver will enable the goals and intent of the program to be met. The District Program Administrator/District Program Manager will respond to the initiator of the request, in writing, within ten working days. Payments to other than a vendor must also be approved by the Division's Business Operations Administrator.

### Ongoing Support

Ongoing Support is an on-going payment to a vendor intended to support the family's effort to maintain its family member with a disability in the family home, thereby preventing out-of-home placement; or to support an adult to live in their own home, thereby preventing placement in more restrictive settings. Payments are made directly to the vendor identified by the member or family or in the case of members living in Individually Designed Living Arrangements (IDLA), payments may be made to the provider who will make payments to landlords, utilities and other living cost on behalf of a member.

When Ongoing Support payments are made to a provider for members living in an IDLA, the provider is required to maintain a detailed expenditures log for each member identifying all expenditures on behalf of the member, including:

- A. Date;
- B. Vendor;
- C. Purchase/payment detail;
- D. Amount;
- E. Declining balance with all supporting documentation and receipts attached.

This expenditure log must be made available to the Division and/or the guardian upon request at any time.

### Eligible Services – Ongoing Support

The Division will only approve services that can be purchased at a reasonable cost and that advance/meet the goals of the Member and Family Assistance program and the Division.

### Ineligible Services

Ongoing Support cannot be used for the following:

- A. Services available under Arizona Long Term Care System;

- B. Members who live in developmental homes, group homes, Intermediate Care Facilities for Persons with an Intellectual Disability, Nursing Facilities or Assisted Living Centers;
- C. Members who have failed to take all reasonable steps to enroll in the Arizona Long Term Care System;
- D. Families with income that exceeds 300% of the federal poverty level. Currently the federal poverty level is \$20,000 for a family of four: 300% = \$60,000 and 29,400 for an individual per the Federal Register which is updated annually.

#### Alternative Options

The Individual Support Plan/Individual Family Services Plan/Person Centered Plan Team members must explore other service options and, if appropriate, applications for alternative services or benefits may be made as a condition of eligibility to receive Ongoing Support. These alternatives include:

- A. Arizona Long Term Care System;
- B. Income supplements such as Supplemental Security Income, Social Security, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Aid to Needy Families, General Assistance and Emergency Assistance;
- C. Food stamps, Women Infants and Children Program and food banks;
- D. Housing benefits available through Housing and Urban Development and other housing assistance;
- E. Vocational Rehabilitation and assistance through the Job Training Partnership Act;
- F. Education programs;
- G. Child support and adoption subsidy;
- H. Arizona Health Care Cost Containment System, Medicare, Indian Health Services and private health insurance;
- I. Supplemental Payment Program and benefits furnished under the Older Americans Act;
- J. Other community and religious based services and programs.

### Eligibility

All members/families must meet the following criteria during any month wherein Ongoing Support is received:

- A. Enrolled in the Division service system;
- B. Participation in the program by parent, other close relative, legal guardian or by the member. This participation usually takes the form of a co-payment for goods or services although it may involve participation in the form of a contribution of labor. Members in an Individually Designed Living Arrangement with no familial supports or source of other income or require extensive supports and medically or behaviorally unable to participate in their own service delivery may be exempt from this requirement.

### Determination of Participation by Responsible Person

Whenever possible, families or members must demonstrate their participation in the cost of service, item or other purchase to be eligible for Community Living Support.

The member must be able to demonstrate how much income is devoted to shelter, food and program cost. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team must approve the programs referenced. The member's remaining resources are available for personal and incidental expenses. Members with more than \$1,500 cash or \$2,000 in liquid assets are ineligible for Ongoing Support. The member's Ongoing Support payment will be interrupted or terminated until they can demonstrate the need for continued or renewed support.

The Support Coordinator and the Planning Team shall review these documents, the family's resources and any funds the member may have:

- A. Savings and checking accounts;
- B. Bonds;
- C. Trust funds;
- D. Tort-feasor (civil judgments) funds;
- E. Annuities;
- F. Estates;
- G. Wages;

- H. Benefits;
- I. Child support payments;
- J. Other financial resources and income.

They shall then submit the request including the items or services to be purchased and amount of family or member participation.

#### Guidelines for Approving Ongoing Support

In evaluating requests for Ongoing Support, the District Program Manager/District Program Administrator (or designee) shall consider the following factors:

- A. Availability of funding;
- B. The likelihood that Ongoing Support will enhance the family's integrity, prevent the need for residential placement, avoid a more restrictive placement, or foster a smooth transition to more independent living for an adult with a developmental disability;
- C. The age and/or health status of the parents/family members;
- D. The complexity of the member's needs, the stress that these place on the family and the family's ability to respond;
- E. The degree of member or family participation in the cost of services relative to their means;
- F. The anticipated duration of the need for service;
- G. The degree to which the family/member is already receiving other Division funded services;
- H. Other resources that may be available to the member/family.

The District Program Manager/District Program Administrator shall approve the response to a request for Ongoing Support funds within 14 working days of the recommendation by the Support Coordinator and Planning Team.

#### Payments

Authorized services, vendor payments and co-payments are identified on the Member and Family Assistance Request Worksheet and Agreement. They must be ongoing payments.

The Ongoing Support Payments may only be made when the initial/prior payment has been verified as expended for the authorized purpose (receipts, or when not available, then via a written, signed statement by the recipient member or family or upon receipt of a bill, rental agreement, invoice or quote from a vendor). In some cases, receipts totaling less than the advanced sum will result in a reduction of the subsequent payment of the Ongoing Support award and will require a return of the unspent supports.

Ongoing supports for food for members living in an Individually Designed Living Arrangement do not require an automatic reduction in the ongoing monthly support unless an ongoing trend in unspent Support is demonstrated, in which case the Support Coordinator shall make a re-determination regarding on the level on Ongoing Support required. Receipts exceeding the authorized amount will not result in an increase in the subsequent payment. In-kind contributions including volunteer time must be documented in writing and submitted along with the receipts.

### Waivers

Waivers of any Ongoing Support procedures, including member or family participation requirements, may be granted by the District Program Manager/District Program Administrator, if the goals and intent of the program are otherwise met.

The member, Support Coordinator or Planning Team may initiate a written waiver request. The request must identify the specific requirements to be waived. The District Program Manager/District Program Administrator will determine whether approval of the waiver request will enable the goals and intent of the program to be met. The District Program Manager/District Program Administrator will respond to the initiator of the request, in writing within ten working of receipt of the request.

### Supplemental Payments Program

The Supplemental Payment Program provides a \$70.00 per month payment for housekeeping services for Division members who meet the following eligibility requirements:

- A. The eligible member must receive Supplemental Security Income payments. If for any reason Supplemental Security Income payments stop, Supplemental Payment Program eligibility is denied.
- B. A statement dated within one year from a physician that diagnoses a disability must be in the member's file.
- C. The need for housekeeping tasks (based on the definitions that follow) must be in the member's file and may be in the form of:

1. Deficiencies on the housekeeping section of the Inventory for Client and Agency Planning.
2. Intake document specifying deficiencies in the area of "capacity for independent living".
3. Other assessments or documentation that specifies the need for housekeeping services.

The following guidelines should be considered before making referrals for Supplemental Payment Program:

- A. Long Term Care Services recipients are not eligible for the Supplemental Payment Program.
- B. Members currently residing in Intermediate Care Facilities for Persons with an Intellectual Disability or group homes are not appropriate for the Supplemental Payment Program.
- C. Members living in independent or semi-independent situations can be referred to the Supplemental Payment Program.
- D. Adults living in their parents' home, relatives' home or guardian's home are appropriate for referral for the Supplemental Payment Program.
- E. Members living in Adult Developmental Homes may be appropriate if the home does not provide housekeeping.
- F. Children living with their parents may be appropriate under the following circumstances:
  1. The child has severe multiple disabilities and requires so much care that the parent(s) is unable to do housekeeping chores.
  2. The child is medically at risk and extraordinary housekeeping is required to keep the home safe and clean for the child
  3. The child frequently engages in behavior that requires constant supervision from the parent, leaving inadequate time for housekeeping or the child engages in behavior that is so destructive and/or messy as to require extraordinary housekeeping measures.
- G. Children living in licensed child developmental homes and foster homes are not appropriate.

Applications for the Supplemental Payment Program are made through the Support Coordinator and are forwarded to the Central Office for approval. The District Program Administrator/District Program Manager shall approve all applications for children. Central Office shall receive the application after District approval. The following questions should be considered when requesting and approving the Supplemental Payment Program for children:

- A. Who currently is doing the family's housekeeping?
- B. Does the child do any housekeeping?
- C. What types of disabilities does the child have and what special attention is needed?
- D. How would the Supplemental Payment Program benefit this family?
- E. What types of duties would the housekeeper perform?
- F. How many people currently live in the home?

An employer-employee relationship exists under which FICA and federal income tax must be paid on wages earned if an independent provider is paid for housekeeping services. A Fiscal Intermediary is available for this responsibility.

The agency is responsible for all taxes if an agency is paid to provide housekeeping services. People who are age 65 and over and who are in need of other Supplemental Payment Program benefits (Home Health Aide and Visiting Nurse Services) should be referred to the Aging and Adult Administration.

## **804 Community Transition Services**

### Description

The Community Transition Service (CTS) assists members eligible for ALTCS to reintegrate into the community by providing financial assistance to move from an ALTCS Long Term Care (LTC) setting to their own home or apartment, excluding licensed community settings.

An ALTCS LTC setting includes one of the following:

- A. Behavioral Health Level I facility,
- B. Institution for Mental Disease,
- C. Inpatient Psychiatric Residential Treatment Center (available to members under 21 years of age eligible for Title XIX.),

- D. Nursing facility, including religious non-medical health care institution, and
- E. Intermediate Care Facility (ICF).

The following items can be purchased using CTS funds:

- A. Security deposits required to obtain a lease on an apartment or home (refunded deposits are the property of the Division).
- B. Essential furnishings (new or gently used including items such as: bed, bedding, towels, table, chairs, window coverings, eating utensils, food preparation items, small electrical appliances).
- C. Moving expenses.
- D. Set up fees or deposits for utility or service access (e.g., telephone, electricity, gas). (Refunded deposits are the property of the Division.)

#### Considerations

The following factors will be considered when assessing the need for this service:

- A. The member has been living in an ALTCS LTC setting a minimum of 60 consecutive days regardless of ALTCS enrollment,
- B. The member is within 30 days of being discharged into the community, and
- C. The LTC setting discharge plan identifies needs and assistance for which the member has no other source or support to move.
  - 1. It is not intended to replace items or supports otherwise provided by the Division or community resources.
  - 2. The member's needs shall be met upon discharge and discharge cannot be delayed in anticipation of receiving services from other sources (e.g., when coordinating with other community sources for the provision of this service).

#### Exclusions

Community Transition Services are:

- A. Not available to members moving from an ALTCS LTC setting to an alternate residential setting such as assisted living facilities, group, or developmental homes.
- B. Limited to a one-time authorization (see exception letter C below) of up to \$2,000 every five years per member.
  - 1. The \$2,000 includes all applicable administration fees.

2. The five year timeframe applies regardless of changes in Managed Care Contractors or the member transfers between fee-for-service and managed care.
- C. Available 30 days prior to the planned discharge date and remain available for 90 days from the date of discharge from an ALTCS LTC institutional setting. Exceptions to this timeframe for partially expended funds will be determined on a case-by-case basis.
- D. Not dispersed to the member, the member's family, or friends.
  1. Funds are paid directly to the vendor identified by the member or family.
  2. Receipts for all purchases using CTS funds shall be retained for a minimum of five years.
  3. The Support Coordinator will assist the member and family with prioritization of needs and facilitate the purchase of identified goods and services.

The following items cannot be purchased using CTS funds:

- A. Cash payments to members or significant others.
- B. Rent.
- C. Leisure/recreational devices (e.g., television or cable access, internet access, stereo).
- D. Aesthetics/decorative items (e.g., picture frames, rugs).
- E. Remodeling improvements to any home or apartment.
- F. Grocery items (e.g., food, personal hygiene, cleaning products).

## **805      Emergency Alert System**

### Description

An Emergency Alert System is a monitoring device/system for members who are unable to access assistance in an emergency situation.

Barring exclusions noted in this section, Emergency Alert System may include:

- A. One emergency alert system unless a second is medically necessary.
- B. The medically necessary accessories for operation.
- C. Voice or touch capability.

- D. Replacement of equipment in cases of loss, irreparable damage, or wear not caused by carelessness or abuse.

### Considerations

The following factors will be considered when assessing the need for this service:

- A. The member lives alone or is alone for eight or more hours without contact with a service provider, family member or other support system and cannot call 911 by using a standard phone, portable phone, or cell phone.
- B. The member's community does not have reliable/available emergency assistance on a 24-hour basis.
- C. The assessment of the member's medical and/or functional level documents an acute or chronic medical condition, which is not improving.
- D. The primary care provider has prescribed the system.

### Settings

An Emergency Alert System may only be provided in the member's own or family home.

### Exclusions

An Emergency Alert System shall not be provided:

- A. To members living in group homes or child/adult developmental homes.
- B. When the member no longer meets the target population/service considerations (e.g., the member moves to a group home or the member is no longer alone for eight hours or more). When this occurs, the system and all components must be returned to the Division.

## **806 Home Modifications**

### Overview

Home Modification is the process of adapting the home to promote the independence and functional ability of persons with disabilities. Adaptations may include physically changing portions of the residence to create a living environment that is functional according to the member's specific needs. Terms often associated

with this process include barrier removal, architectural access, assistive technology, retrofitting, home modifications, environmental access or universal design.

Members who are eligible for the ALTCS are also eligible for medically necessary home modifications for architectural access to and within his/her natural/private home. The goal of a home modification is to provide the person greater independence and ability with assistance for daily living in their home.

Home modifications must be medically necessary, cost-effective and reduce the risk of an increase in home community based services or institutionalization.

A Home Assessment will be done to develop an individualized home modifications plan. The plan will ensure that only appropriate diagnosis related modifications be completed in the home. This plan also provides for a cost-effective, predictable, medically beneficial and measurable rehabilitative service for the member.

The Division must approve or deny requests for home modifications within 14 calendar days from the "identified need date". A request that requires an additional extension for up to 14 days and is in the member's best interest requires the member receive written notice including the reason for the extension. The Support Coordinator should request an assessment via the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process when attempting to identify the most appropriate modification for the member. The Planning Team identifies the need for a home modification assessment only. The assessment must be completed within 30 days. A certified staff person must conduct a home visit to make this assessment. The "identified need date" is determined at the time the team agrees to the recommendations as a result of the assessment.

When a request is for a specific home modification such as a curbless shower, "handrails," widen doors etc., the Support Coordinator via the Planning Document can make a request for that specific modification. The "identified need date" starts at this time and the request for home modifications must be approved or denied within 14 days. A request that requires an additional extension for up to 14 days and is in the member's best interest requires the member receive written notice including the reason for the extension. This method may result in a denial of service. The home modification unit would make a broad "contingent" recommendation if sufficient evidence is present to move forward with the request.

#### Scope of Home Modifications

The unit of service is one home modification project. Using the member's primary and secondary diagnoses in conjunction with a home evaluation, a project plan to provide home modification for the person will include, but not be limited to, the following areas of the home: The:

- A. Member's bedroom;
- B. Most appropriate, cost-effective bathroom;
- C. Most appropriate, cost-effective entrance/exit to the member's home, i.e., a ramp;
- D. Most appropriate, cost effective locations of the kitchen area, when determined to be medically necessary when the member lives alone.

The types of permanent installations for architectural barrier removal include:

- A. Widening of doorways – entrance and exit to one bathroom and the member's bedroom.
- B. Accessible routes to one bathroom and the member's bedroom.
- C. One bathroom environment; (roll-in/curb-less) accessible shower, roll-under sink, high rise toilet with handrails, handrails and grab bars in accessible shower, has prescribed.
- D. One wooden or concrete ramp/low inclined walkway.
- E. Kitchen modifications; accessible cooking surface, minimum accessible pantry storage, accessible kitchen sink/faucet. Kitchen modifications are considered medically necessary when the member lives alone and cannot independently prepare necessary meals without modifications.

Home Modification recommendations (i.e. curb-less showers) will consider the use of durable medical equipment (shower chair) to be used; the Health Care Services Office can provide technical assistance on durable medical equipment. The member must request any new Durable Medical Equipment via their Primary Care Provider (PCP) who forwards the need to their contracted health plan.

#### Home Repairs, Home Improvement

General home repairs and maintenance are the responsibility of the homeowner. Home Modifications are for medically necessary environmental access and do not intend to include remodeling for home improvement or home safety. Although home safety is an outcome from architectural barrier removal when home modifications have been completed, it is the responsibility of the homeowner to ensure the home is safe; and to maintain important safe entrances from the home in case of emergency, for all inhabitants. Requests for home modifications that are determined to be for home repairs, home improvement or home safety will be denied.

Repairs will be carried out to existing structures only when the approved modifications have begun and cannot be completed because of unforeseen circumstances. These repairs must be necessary for building code correction, thereby granting the building contractor the ability to achieve completion of approved medical environmental modifications.

### New Construction

The service covers only modifications to existing structures of a member/family owned home where the person resides. Members/families that are planning for a new home are responsible for all the architectural access design/construction of a new home. The service does not cover the construction of additional rooms to the existing structure or provide for an additional bathroom. Technical assistance may be available to help with environmental access.

### Homes Not Owned by the Member (Rental/Lease)

The owner of the residence must approve the modifications. When the home being considered for home modifications is not owned but is rented or leased by the family/member, documentation providing permission to allow for renovations on behalf of the member is required from the landlord/owner. Written confirmation must include agreement of participation, signature of the landlord/owner with indication of ownership and address of residence requested for environmental access.

The Division, in compliance with A. R. S. § 41-1491.19.D.1 ([www.azleg.gov/ArizonaRevisedStatutes.asp](http://www.azleg.gov/ArizonaRevisedStatutes.asp)), will incur the cost to restore the home to the original condition prior to the renovation when the landlord/owner requires such after the member has vacated the property.

No Title XIX funds may be used to return a home to its pre-modification state as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy ([www.azahcccs.gov/Regulations](http://www.azahcccs.gov/Regulations)).

It will be the responsibility of the landlord/owner to demonstrate that the removal of architectural barriers in the rented unit will result in the inability to negotiate a new rental agreement with another member or family. The landlord/owner must also demonstrate that it is a financial disadvantage to maintain environmental access to the rented unit. Additionally, the landlord/owner must demonstrate that the unit will not retain the retail value of a single family dwelling because of the removal of architectural barriers.

### Requirements for Medically Necessary Environmental Modifications

Requests for the environmental access to the person's home must include all the following:

- A. The need for environmental access documented in the member's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan.
- B. Long Term Care Primary Care Provider order.
- C. An assessment by a qualified professional, i.e., occupational therapist, physical therapist or Certified Environmental Access Consultant. The Division's Medical Director must be contacted to review the request if an assessment by a qualified professional cannot be obtained.
- D. An authorization by the Home Modifications Manager.
- E. The evidence that the member resides in a private residence. Members residing in alternative residential settings are not eligible to receive Home Modifications.

If the request is denied due to lack of medical necessity, it may be authorized, approved or paid by Assistance to Families funds. Medically contraindicated requests shall not be authorized.

### Procedures

When a member has recognized a need for home modifications, a request for a home modification begins by contacting the member's Support Coordinator.

The Support Coordinator will forward the request to the Home Modifications Office using the "Initial Request for Home Visit" fax form upon receipt of a member's request for a home modification. This request must be made via the Individual Support Plan/Person Centered Plan process. A written order by a PCP is another way to make this request. Requests for a home modification may also be made using a home assessment from a physical/occupational therapist.

At the time of request for home modifications the Support Coordinator shall enter into the case file via the "Individual Support Plan" or the "Change of Individual Support Plan" form, the need for an assessment to determine specific modifications.

The date recorded in the member's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) becomes the date for the request for an assessment. This request date determines the beginning of the required 30 days to complete a home visit and assessment. Once the assessment is completed, the team can request the specific modifications and the date of this request becomes the "need identified" date.

The Division must approve or deny requests for home modification within 14 days of the identification of need date. A request that requires an additional extension

for up to 14 days and is in the member's best interest requires the member receive written notice including the reason for the extension. Projects should be completed as soon as possible following approval, not to exceed 90 days. Extenuating circumstances that prevent project completion within 90 days of approval will be documented in the member's case record.

A scheduled home assessment will be conducted within 30 days after the Home Modification unit in Central Office receives a request. The Support Coordinator must be present during the home environmental assessment.

The purpose of a home modification is to increase a member's independence. The home visit will assess the relationship of the member's ability to function independently in the current environment as a result of the proposed home modifications. The home visit will also coordinate the Home Modification Packet production.

The home assessment will include:

- A. Consideration for member's abilities and disabilities based upon aids to daily living.
- B. Consideration of information that is obtained from the member, family or others in the household and members of the Planning Team.
- C. Consideration of hazardous areas of the home based on physical and/or cognitive/intellectual disabilities.
- D. Identification of the Planning Documents needs as they relate to delivering services to the member.
- E. Identification of diagnosis-related modifications.
- F. Provisions for necessary assistive devices and durable medical equipment.
- G. Provisions for necessary architectural barrier removal.
- H. Recording architectural measurements of floor plans and specification sheet.

Review the required documents for the Home Modifications Packet with the member's Support Coordinator. This includes:

- A. Reviewing the Professional Assessment for environmental access. An Occupational Therapist, Physical Therapist or Certified Environmental Access Consultant for the project can provide the professional assessment. A review may be requested from the Division's Medical

Director if a professional assessment cannot be obtained at all or obtained in a timely fashion.

- B. Obtaining the PCP order for the project using the prescription form approved by the AHCCCS at 15 days from the "need identified" date. After this 15-day period, the Home Modifications unit will send a second prescription form to the PCP with instructions that services will be denied if the prescription form is not received.
- C. Obtaining the Project Specification Sheet and Floor Plans. The Home Modification Office will be responsible for the development and implementation of the Project Specification Sheet and drafting of floor plans for each Project. A bid request will be forwarded to the appropriate providers. The Home Modifications Unit will review and award the bid to the approved provider upon return of the proposal.

The following authorities will be used as reference for determining accessibility and defining a living environment that provides greater independence and architectural access for the member upon developing the Project Specification Sheet. These include Uniform Building Code Chapter 11 - Accessibility, and guidelines in accordance with the Americans with Disabilities Act. *Note:* The Division will only approve medically beneficial, cost-effective environmental access.

Obtain Home Modification Bid(s) - (2 bids should be obtained). The Division will use only a licensed, bonded/insured - B or B3 Contractor/Builder for the accessible renovation of the member's residence as defined under A.R.S. § 32-1101.01 [www.azleg.gov/ArizonaRevisedStatutes.asp](http://www.azleg.gov/ArizonaRevisedStatutes.asp).

Complete the *Environmental Modifications Request Form* to track progress of the project. Ensure that member's identification information, Provider/Contractor name, cost of service, the signatures of the Support Coordinator, supervisor and District Program Administrator/District Program Manager or designee (cost of service must be indicated prior to submitting to the District Program Administrator/District Program Manager) are included. The project can be approved and started whether or not the form has been completed but must be completed to ensure everyone has knowledge of the project and the project costs.

Submit the project packet to the Home Modification Office for review/approval.

The packet will include the following:

- A. Environmental Modifications Request.
- B. Member's Planning Documents (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan) indicating need for medical environmental access.

- C. Professional assessment dated within time of request or review with signature from Division's Medical Director.
- D. Primary Care Provider (PCP) order dated within time of request.
- E. Project Specification Sheet and Floor plan (before and after, site plan).
- F. Contractor bids.

### Review Procedures

The Home Modifications Manager will ensure the District representative has reviewed costs and signatures are present upon receipt of the Project Packet.

The Home Modifications Manager will review and sign the request only upon verification that all necessary documents have been provided.

A second level of approval will be required if a Home Modification Project Packet has a total project cost greater than \$9000.00. The Home Modifications Manager will forward the project packet to the Assistant Director or designee for review and a final decision. The second level review will be monitored as to avoid delay and maintain Project Packet progress within required time frames.

## **807 Habilitation, Early Childhood Autism Specialized**

### Description

This service provides a variety of interventions to maximize the independence and functioning of young children with autism or at risk for autism, such as special developmental skills, behavior intervention, and sensorimotor development. Additionally, this service is designed to teach and strengthen the skills of the parent/caregiver through participation when this service is provided.

This service may be a combination of Habilitation Doctoral or Masters (ECM) and Habilitation Bachelors (ECB). It is authorized concurrently with Habilitation Hourly (ECH), and must be provided to one child at a time. The ECM, ECB, and ECH are authorized to the same Qualified Vendor.

The service hours provided by the Masters Level Consultant and the Bachelors Level Consultant combined may not exceed 150 hours per child for a two-year period. Prior to the end of the two-year period, all progress reports will be reviewed to determine progress and the continued need for the service. If the service is determined to be medically necessary based on the review of the data and documentation, authorization will be issued in six month increments (six units per month) as long as medically necessary, but only until the child is eligible for a first grade school program.

No additional hours of of ECM/ECB will be authorized in the extension period until the initial 150 hours have been used.

Barring exclusions noted in this section, Habilitation Doctoral or Masters and Bachelors may include the following:

Habilitation Doctoral or Masters (ECM)

The functions below are provided by an HBM Consultant:

- A. Up to 20 hours for the initial intake and assessment, that includes:
  - 1. Development of the plan for Habilitation Doctoral/Masters/Bachelors intervention.
  - 2. Development of treatment goals including hourly Habilitation (ECH) hours needed to implement.
  - 3. Development of a home program. The home program provides for specific activities for families/caregivers to engage with their child during the course of their daily activities to enhance progress towards the chosen treatment goals.
- B. Completion of the baseline Vineland Scales of Adaptive Functioning or other tools to measure adaptive functioning as approved by the Division.
- C. Report writing.
- D. Re-assessment using the Vineland Scales of Adaptive Functioning or other industry accepted tool to be administered after one year of treatment and again after one year, nine months of treatment.

Habilitation Doctoral or Masters (ECM)/Habilitation Bachelors (ECB)

The functions below are provided by an ECM or ECB Consultant:

- A. Training for the parent/caregivers and habilitation provider(s) within the first 90 days of service that includes:
  - 1. Modeling implementation of the specific activities with the child while the Habilitation provider and or parents/caregivers are observing.
  - 2. Observing the Habilitation provider or parent/caregiver implement the plan.
- B. With hours remaining in the initial 150 hour authorization, providing consultative oversight to parent/caregivers and ECH providers after the first 90 days of service.

Habilitation (ECH) Hours

- A. The number of ECH hours is determined by the ECM Consultant's assessment.
- B. The approval of ECH hours as recommended in the ECM Consultant's assessment and authorized by the Division must be coordinated with

the authorization of the ECM/ECB hours (i.e., the approval of ECH and ECM/ECB are for the same service period and terminate at the same time).

- C. The ECH provider will follow the plan/treatment goals developed by the ECM/ECB provider when authorization of habilitation hourly is in conjunction with the ECM/ECB program.

#### Responsible Person's Participation

This service requires participation from parent/caregivers to maximize the benefit of the service and improve outcomes for the child. As part of this service parents and caregivers:

- A. Must participate in training provided by a qualified ECM/ECB Consultant/provider on the specific activities developed for their child.
- B. Must implement the home program (specific strategies) developed by the ECM/ECB Consultant as described in this section.
- C. Are expected to attend and participate in the ECH sessions, which include the ECM or ECB Consultant, and in any modification of the Program during the course of treatment. This is to ensure that the goals important to the family are included and to provide additional guidance on the specific strategies.

#### Considerations

Using the assessment and plan development processes described in this policy manual, the Support Coordinator will consider the following factors when assessing the need for this service:

- A. Eligibility must be determined prior to the age of four.
- B. The child must be eligible for ALTCS.
- C. Parents'/caregivers' ability and interest in participation in service delivery.
  - 1. The ECM Consultant must identify a clinical reason for lack of participation and document this reason in the Planning Document; (e.g., the presence of the parent/caregiver interferes with the teaching of a specific skill/task).
  - 2. When the parent/caregiver is unable to participate, the team must identify other natural or paid supports or services which will allow the parents to participate.
- D. An assessment/evaluation by a Psychiatrist, Developmental Pediatrician, or a Licensed Psychologist that identifies the child as having or at risk for having autism and learning and/ or behavior challenges that are likely to continue without intensive behavioral instruction.

- E. Identification of the need in the child's Planning Document.

Settings

This service may be provided:

- A. Hourly in the member's home.
- B. Hourly in other community settings or activities (e.g., participation in religious activities, shopping with the family).

Exclusions

This service shall not be provided in school or in transit to and from schools.