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100 INTRODUCTION

101 Overview

This chapter provides an introduction to the Department of Economic Security/Division of Developmental Disabilities (Division) Policy Manual. It describes how the Manual is developed and how revisions are made and distributed to the Division staff, members, families, constituency groups, Individual Independent Providers, Qualified Vendors, and Contractors.

In order to make sure references to government agencies, division documents, job titles and practices are understood, the Division will continue to make every attempt to spell out acronyms on relevant pages at least once per page.

102 Development/Revision of Policies

The Division adheres to all State and federal laws, regulations and rules that relate to the operation of the Division and the programs it administers. The Division is required to develop policies for program operations that conform to State and federal requirements.

During the policy development and revision processes, comments may be solicited from appropriate Central Office and District staff, members, families, providers, advocates, other government agencies, constituency groups and advisory groups as required by state law or desired by the Division. All policies must be approved by the Division's Assistant Director.

Requests for Manual revisions which affect the Division should be directed to the Policy Manager.

Revised Manual sections for Division policies are identified by a revision date in the lower left corner of each page.

Requests for policy development/revision which affect other department programs are initiated through the Assistant Director for each division and processed through the Department of Economic Security's Policy and Procedures Administration. Additional information regarding the process for development/review of "universal" policies and procedures can be found at http://deswebpro.azdes.gov/cms400min/dllist.aspx?type=1 under the Administrative Policies button (DES1-01-25).

103 Distribution of New Policies

Policy Manual issuances are distributed electronically through the Division's website at https://www.azdes.gov/ddd/. The Division maintains a master mailing list and manages the notification, distribution process for those who request individualized notice. Questions regarding this process should be directed to the Policy Manager.

104 Annual Policy Review

The Division will review all policies annually. After the review and recommended revisions are made, the Assistant Director or designee shall approve all final policies.

The Division will track and maintain a record of reviews and recommended revisions for policy drafts.

CHAPTER 200 - DEFINITIONS

REVISION DATE: 03/02/2015, 09/01/2014, 05/01/2014
INITIAL IMPLEMENTATION DATE: October 1, 2012
REFERENCES: Arizona Heath Care Cost Containment System (AHCCCS), Arizona Administrative Code, Arizona Revised Statutes

1115 Waiver – The 1115 Waiver refers to section 1115 of the Social Security Act (SSA). States must comply with Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program) of the SSA. Since Arizona began providing Medicaid on October 1, 1982, the Arizona Health Care Cost Containment System (AHCCCS) has been exempt from specific provisions of the SSA, pursuant to an 1115 Research and Demonstration Waiver. The 1115 Waiver specifies provisions in the SSA and corresponding regulations AHCCCS is exempt from; terms and conditions that AHCCCS must fulfill; and approved federal budget amounts. (Arizona Section 1115 Demonstration Project Waiver)

Arizona Administrative Code (A.A.C.) - The Arizona Administrative Code is a publication of the official rules of the State of Arizona. Rules are adopted by state agencies, boards or commissions, with specific rulemaking authority from the State Legislature. Rule sections are published in Titles and Chapters.

Arizona Developmental Disabilities Planning Council (ADDPC) –The ADDPC works to support advocacy, bring about systems change and create increased capacity to support persons with developmental disabilities in the community. The ADDPC was established pursuant to Public Law 106-402, also known as the Developmental Disabilities Assistance and Bill of Rights Act of 2000. Pursuant of an Executive Order by the Governor of the State of Arizona on September 3, 2009, the Council was created. Council members are appointed by the Governor of Arizona.

Arizona Health Care Cost Containment System (AHCCCS) – The single State Medicaid agency, as described in A.R.S. Title 36, Chapter 29, Arizona Medicaid Agency. AHCCCS is composed of the AHCCCS Administration, Contractors and other arrangements through which health care services (acute, long-term care, and behavioral) are provided to members.

Arizona Long Term Care System (ALTCS)- An AHCCCS program which delivers long term, acute, behavioral health care, and case management services as authorized by A.R.S. § 36-2931 et seq, to eligible members who are either elderly and/or have physical disabilities and to members with developmental disabilities,

through contractual agreements and other arrangements.

Arizona Long Term Care System (ALTCS) Contractor- A contracted managed care organization (also known as a Program Contractor), that provides long term care, acute care, behavioral health and case management services to Title XIX eligible individuals who are either elderly and/or who have physical or developmental disabilities who are determined to be at immediate risk of institutionalization.

Arizona Revised Statute (A.R.S. §) - Laws of the State of Arizona.

Assistant Director Approval – Includes approval from the Assistant Director's designee.

Behavioral Health Service Plan (ISP) – A Behavioral Health Service Plan (also referred to as "service plan" and "treatment plan" or Individual Service Plan (ISP) by behavioral health divisions, organizations and providers) is a written description of the covered behavioral health services and other informal supports that have been identified through the assessment process that will assist the person to meet his/her specified goals. The Behavioral Health Service Plan is developed by the Regional Behavioral Health Authority (RBHA) provider and becomes part of the Division's ISP document.

Behavioral Health Service – Behavioral health services begin with an assessment and diagnosis from a behavioral health professional. Based on medical necessity, this service includes a Behavioral Health Individual Service Plan (ISP) and a treatment plan that may include medication, therapy services and other supports.

Centers for Medicare and Medicaid Services (CMS) – An organization within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs and the State Children's Health Insurance Program (known as KidsCare in Arizona).

Code of Federal Regulations (CFR) - The general and permanent rules published in the Federal Register by the departments and agencies of the federal government.

Contractor - An organization, person, or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. § 36-2904 to provide goods and services to members, either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS statutes and rules, and Federal law and regulations.

Developmental Disabilities Advisory Council (DDAC) – Advisory Council to the

Division of Developmental Disabilities whose duties have been established by A.R.S. § 36-553 whose voting members are also appointed by the Governor of Arizona.

Direct Care Worker – A person who assists individuals with activities necessary to allow them to reside in their home. These workers may also be known as Direct Support Professionals.

Durable Medical Equipment (DME) – An item or appliance that is not an orthotic or prosthetic; is designed for medical purpose; is generally not useful to a person in the absence of an illness or injury; can withstand repeated use; and is generally reusable by others.

Durable Medical Equipment (DME), Customized - Equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

Fee-For-Service (FFS) - A method of payment to an AHCCCS registered provider on an amount-per-service basis.

Focus – The automated web-based system used to maintain information on each member eligible for the Division.

Home and Community Based Services (HCBS) - Services provided, in lieu of institutionalization, to ALTCS members who reside in their own home or in an ALTCS approved home and community based alternative residential setting in order to maintain the member's highest level of functioning. Members enrolled in the ALTCS Transitional Program also receive HCBS.

Home Program – The Home Program provides for specific activities for the member to do with their families/caregivers during the course of their daily activities to enhance progress towards the chosen treatment goals.

Human Rights Committee (HRC) – This Committee provides independent oversight to monitor and ensure the civil and human rights for persons with developmental disabilities as guaranteed in the U.S. Constitution, Federal law regulations, and the Arizona Revised Statutes.

Individualized Education Program (IEP) - Every child receiving special education services under the Individuals with Disabilities Education Act (IDEA), must have an IEP. IEP is a written statement of the educational program designed to meet a child’s individual needs developed by the local school district.

Individual Family Service Plan (IFSP) - The IFSP is a written plan for providing early intervention services to children birth to age 3 and their families who are eligible for and participating in the Arizona Early Intervention Program. (www.azdes.gov/azeip)

Institutional Settings – Means a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).

Medically Necessary - As defined in A.A.C. R9-22-101, medically necessary means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse conditions or their progression, or to prolong life.

Member – A person enrolled with the Division of Developmental Disabilities.

Planning Document – A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Individualized Support Plan (ISP), and Person Centered Plan (PCP).

Primary Care Provider (PCP) - An individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

Prior Authorization (PA) – Process by which the Division approves a service.

Program Review Committee (PRC) – As defined in agency rules at A.A.C. R6-6-903, the PRC is an assembly designated by the District Program Manager that reviews any behavior treatment plans which meet the criteria also outlined in the same rules. The PRC approves plans, or makes recommendations for changes as necessary.

Regional Behavioral Health Authority (RBHA) – As defined in A.R.S. § 36-3401, the RBHA is an organization under contract with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) to administer covered behavioral health services in a geographically specific service area of the state. Tribal governments, through an agreement with the

ADHS/DBHS, may operate a Tribal Regional Behavioral Health Authority (TRBHA), as defined in A.A.C. R9-22-1201(w), for the provision of behavioral health services to American Indian members living on-reservation. Through an intergovernmental agreement with ADHS/DBHS, the Division is responsible for all behavioral health services provided to members eligible for ALTCS.

Service Plan Year – The annual period of time beginning at the member's "ISP Start Date" as identified in Focus through the "ISP End Date" as identified in Focus.

Title XIX - Known as Medicaid, Title XIX of the Social Security Act provides for federal funds to the states for medical assistance programs.

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300 MEMBER RIGHTS AND RESPONSIBILITIES

301 Overview

The Division of Developmental Disabilities (DDD) is especially concerned with protecting the rights of all members who are receiving supports and services operated by, supervised or financially supported by the Division. This chapter discusses basic human and disability-related rights and responsibilities; Human Rights Committees, informed consent of individuals receiving supports and services, and advance directives/living wills in Arizona. Mention of specific rights in this chapter is not meant to be all-inclusive.

While individuals with disabilities have certain rights, there are also certain responsibilities when reaching adulthood. These responsibilities are the same as for adults without disabilities.

302 Basic Human and Disability Related Rights

Arizona Revised Statutes (A.R.S.) clearly recognizes that a person with a developmental disability has the rights, benefits, and privileges guaranteed by the constitutions and laws of the United States and the State of Arizona.

A.R.S. §41-3801
http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp

The rights of a person with a developmental disability receiving supports and services through the Division include the:

A. Right to an initial Individual Support Plan/Individualized Family Services Plan (ISP/IFSP) planning document prior to receiving supports and services.

B. Right to participate in the ISP/lFSP, periodic evaluations, and whenever possible, the opportunity to select among appropriate alternative supports and services.

C. Right (once accepted for supports and services) to participate and share in decision making, and to receive a written ISP based upon relevant results of the placement evaluation.

D. Right to information regarding the supports and services available through a provider and about related charges, including any fees for supports and services not covered by a third-party payor.

E. Right to a periodic review of the ISP/IFSP planning document.

F. Right to be given written notice of his/her rights.

G. Right to exercise his/her rights as a citizen.

H. Right to live in the least restrictive setting. A least restrictive setting refers to an environment in which a member strives to reach his/her full potential in accordance to the tenets of self-determination.

I. Right to protection from physical, verbal, sexual or psychological abuse or punishment.

J. Right to equal employment opportunity.

K. Right to fair compensation for labor.

L. Right to own, rent, or lease property.

M. Right to marry and have children.

N. Right to be free from involuntary sterilization.

O. Right to express human sexuality and receive appropriate training.

P. Right to consume alcoholic beverages if 21 years of age or older unless contraindicated by orders of his/her primary care provider or the court.

Q. Right to presumption of legal competency in guardianship proceedings.

R. Right to be free from unnecessary and excessive medication.

S. Right to be accorded privacy during treatment and care of personal needs.

T. Right to confidentiality of information and medical records.

U. Right of a school age member to receive publicly supported educational services.

V. Right of a child to receive appropriate supports and services, subject to available appropriations, which do not require the relinquishment or restriction of parental rights or custody, except as prescribed in A.R.S. § 8-533, which describes the grounds needed to justify the termination of the parent-child relationship.

W. Right to consent to or withhold consent from participation in a research project approved by the Division management team or any other research project; right to knowledge regarding the nature of the research, potential effects of a treatment procedure as part of a research project; right to confidentiality; and the right to withdraw

from the research project at any time.

X. Right of a person who believes his/her, rights have been violated to petition the Superior Court for redress, unless other remedies exist under federal or State laws.

Y. Right to withdraw from programs, supports and services, unless the member was assigned to the Department by the juvenile court or placed in a secure facility by the guardian and court.

Z. Right to an administrative review, if in disagreement with a decision made by the Division, by filing a verbal or written request for such with the DDD Office of Compliance and Review, and the right to appeal the decision. (See Chapter 2200)

1. Right to contact the Human Rights Committee.

2. Right to be free from personal and financial exploitation.

3. The right to have care for personal need provided, except for cases of emergency, by a direct care staff of the gender chosen by the responsible person, this choice shall be specified in the Planning Document.

U.S.C. Annotated 42-12010, et seq. **http://www.gpo.gov/fdsys/**

A.R.S. § 41-1492, et seq.

A.R.S. § 36-554(A)(l 0)

A.R.S. § 36-551(01)(0)

A.R.S. § 36-568(01)

A.R.S. § 41-1959

http://www.azleg.gov/

A.A.C. R6-6-104

A.A.C. R6-6-102(C)

A.A.C. R6-6-804 (9)

A.A.C. R6-6-901-910

A.A.C. R6-6-102(C)

A.A.C. R6-6-1801, et seq.

A.A.C. R6-6-2002-2003

http://www.azsos.gov/public_services/

302.1 Voter Registration

All support coordination staff must comply with the Arizona Department of Economic Security Policy DES 1-01-24, regarding the National Voter Registration Act of 1993, and applicable state statutes, by offering individuals applying for services the opportunity to register to vote.

Staff will accept the verification of U.S. Citizenship that the consumer presents, but are NOT required to verify that it is an acceptable U.S. Citizenship document.

Staff will sign the acknowledgement form to indicate they have reviewed and understand the policy. The acknowledgement must be signed by new employees within 60 days of hire. The signed copy is maintained in the Supervisor's file.

302.2 The Rights of Persons with Developmental Disabilities Living in Residential Settings

Additional rights of persons with developmental disabilities who reside in residential settings such as group homes, adult and child developmental homes, or an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) include the basic human and disability-related rights listed previously. Because of the special circumstances of living in a residential facility,
specific rights have been delineated. These rights include the:

A. Right to be informed of the rules of the residential setting in which he/she is living.

B. Right to impartial access to treatment and/or accommodations.

C. Right to a safe, humane, and clean physical environment.

D. Right to communicate with those responsible for his/her care.

E. Right to choose his/her personal care provider from the health plan(s) available.

F. Right to be informed of his/her medical condition, of any technical procedures that will be performed, of the identity of the persons who will perform the procedures, attendant risks of treatment and the right to refuse treatment.

G. Right to be free from unnecessary drugs and physical restraints, except as authorized in writing by a physician for a specified time period and in accordance with the Division rules regarding behavior supports.

H. Right to a physical examination, prompt medical attention and to adequate food and water.

I. Right to his/her own bed.

J. Right to personal clothing and possessions as space permits, unless this infringes on the rights of others or is medically contraindicated.

K. Right to be accorded privacy with regard to written correspondence, telephone communication, and visitors.

L. Right of a husband and wife who both reside in a facility to share a room.

M. Right to privacy during visits by a spouse.

N. Right to refuse to talk with or see someone.

O. Right to participate in social, religious and community group activities.

P. Right to manage his/her own financial affairs and to be taught to do so to the extent of his/her capabilities.

Q. Right to refuse to perform services for the facility, but if he/she does provide services, right to be compensated at prevailing wages commensurate within state and federal laws and as prescribed by the Industrial Commission.

A.R.S §23-363 **http://www.azleg.gov/**

R. Right to have the Division supervisors advised of any unusual incident.

S. Right to file a grievance not only with the Division but also with his/her health plan, the Arizona Long Term Care System (ALTCS) and Arizona Health Care Cost Containment System (AHCCCS).

42 CFR 438.420(a)
http://www.gpo.gov/fdsys/

Arizona Administrative Code R6-6-901, et seq.
Arizona Administrative Code R6-6-107
http://www.azsos.gov/public_services/

AHCCCS Contractor Operations Manual

azahcccs.gov/Regulations/lawsregulations.aspx

T. Right to the least amount of physical assistance necessary to accomplish a task.

U. Right to have care for personal needs provided, except in cases of emergency, by a direct care staff of the gender chosen by the individual/responsible person. This choice shall be specified in the ISP/IFSP planning document.

302.3 Responsibilities of Individuals Applying for and/or Receiving Supports and Services

Applying for and/or Receiving Supports and Services

Individuals with developmental disabilities are to be supported in exercising the same rights and choices and afforded the same opportunities enjoyed by other citizens. The Division provides this support by following the principles of self-determination. Self-determination is the ability of a member to make choices that allow him/her to exert control over his/her life and destiny, to reach the goals he/she has set, and take part fully in the world around him/her. To be self-determined requires that a member has the freedom to be in charge of his/her life, choosing where to live, who to spend his/her time with and how to spend his/her time. Decisions made by the member about his/her quality of life should be without undue influence or interference of others. Self-determination also necessitates that the member has the resources needed to make responsible decisions.

Self-determination is necessary because people who have disabilities often desire greater control of their lives so they can experience the life they envision for themselves, one that is consistent with their own values, preferences, strengths and needs. For individuals receiving services through the Division, one way to exert greater control of their lives is to choose the supports and services they receive and who provides that support. The Division offers many options for a Member wanting to make more choices about services and supports, such as:

A. Selecting a Support Coordinator.

B. Selecting and directing their planning process, either an Individual Support Plan and/or a Person-Centered Plan.

C. Selecting service providers, both qualified vendors and individual independent providers.

D. Hiring, managing, and firing service providers.

E. Using a fiscal intermediary to manage the financial aspects of having a service provider who is his/her employee.

F. Having the spouse serve as his/her provider.

Responsibilities

Making more choices and exerting more control over one's life also means assuming some amount of responsibility. Individuals applying for and/or receiving supports and services through the Division have certain responsibilities. These responsibilities begin when a person applies for services by providing the Division with accurate and complete personal information on the application. These responsibilities continue once a Member is determined eligible, for example, by being actively involved in developing, implementing, and monitoring the ISP/IFSP planning document. These responsibilities last throughout the duration of services, through actions such as being respectful of the rights and property of others.

The Division encourages individuals to assume some reasonable responsibilities for the success of their supports and services. Their increased involvement in their care increases the likelihood of achieving the best results. Therefore, fulfilling these responsibilities is important as they contribute to the success of the Division's supports and services.

Individuals receiving supports and services from the Division have a responsibility to:

A. Cooperate with the Division staff by providing required information relative to personal information required on the application. When accepted for supports and services the Member is responsible for informing his/her Support Coordinator of any change in such data.

B. Participate in the development of his/her ISP planning document and to signify agreement or disagreement by signing the planning document.

C. Assign to the Division rights to first party health insurance medical benefits to which the Member is entitled and which relate to the specific supports and services, which the person has received or will receive as part of his/her ISP/IFSP planning document.

D. Uphold all laws local, state, and federal bodies.

Individuals applying for and/or consumers receiving, supports and services through the Arizona Long Term Care System (ALTCS) have additional responsibility to:

A. Provide accurate and complete information regarding his/her health history.

B. Report unexpected changes in his/her health status.

C. Follow the recommendations of the planning team, or the responsibility for his/her actions if the recommendations as documented are not followed as prescribed. (In some cases, the plan may need revision if it has been deemed ineffective.)

D. Be considerate of the rights of other residents and facility personnel in regards to personal behavior, control of noise and number of visitors.

E. Be respectful of others property.

A.R.S § 36-596(B)
http://www.azleg.gov/

A.A.C. R6-6-401
A.A.C R6-6-603
http://www.azsos.gov/PUBLIC_SERVICES/

AHCCCS Medical Policy Manual
http://azahcccs.gov/Regulations/lawsregulations.aspx

302.4 Procedures

The following summarizes some of the major tasks of a Support Coordinator relative to protecting the rights of individuals who are receiving supports and services through the Division:

A. During the intake process, the Support Coordinator must explain to the individual/responsible person his/her rights and offer or give him/her a printed copy of the *Statement of Rights* and a copy of the Human Rights Committee's brochure. The member/responsible person must sign a statement indicating that he/she has received a copy of these rights and that they have been explained to him/her. The signed statement must be placed in the individual's file and a copy must be given to the individual/responsible person.

The Arizona Early Intervention Program (AzEIP) Rights Booklet

should be given to the responsible person for children who are eligible for the AzEIP program at intake.

B. As part of the initial ISP/IFSP planning meeting, the Support Coordinator must offer/provide a copy of the *Statement of Rights* to the individual/responsible person, if this was not done at intake. The responsible person must sign a statement indicating they have received a copy of these rights and that these rights have been explained. The signed statement must be placed in the individual's file and a copy must be given to the individual/responsible person.

C. The Support Coordinator will assist individuals as necessary or as requested in applying for Arizona Long Term Care System (ALTCS) services and in filing a grievance and/or a request for an administrative review.

D. The Support Coordinator shall follow up on any report that an individual's rights have been violated by filing an incident report with the District Program Manager/Administrator.

E. At the ISP/IFSP Planning Team meeting prior to or after a Member becomes of legal age, whichever is closer in time, the Support Coordinator shall:

1. Remind the Planning Team of the date on which the Member will become of legal age.

2. Inform the individual/responsible person verbally of his/her new legal rights as an adult.

302.5 District Human Rights Committees

Human Rights Committees are local groups of citizens who provide independent oversight in matters related to the rights of persons with developmental disabilities who are served by the Division. Each Human Rights Committee must meet at least six times each calendar year, but as often as necessary as determined by the chair in accordance with the bylaws of the committee.

Specifically, the Human Rights Committee reviews the rights of individuals in the following areas:

A. Administration either of medication, which changes recipient’s behavior directly, or as a side effect.

B. Aversive or intrusive programs.

C. Research proposals in the field of developmental disabilities, which directly involve individuals receiving supports and services.

D. Incidents of possible abuse, neglect, or violations of an individual's rights.

Any suspected violation of the rights of a person with developmental disabilities should be identified to the appropriate Human Rights Committee.

In addition to protecting the rights of individuals, the Human Rights Committee must:

A. Submit in writing to the Division Assistant Director any objections it has to actions by employees of the Division or employees of service providers.

B. Issue an annual report, in concert with the Quality Assurance Unit, summarizing its activities and making recommendations of changes it believes the Division should consider implementing.

There are several Human Rights Committees in the state, each serving one or more counties. For further information on the Human Rights Committee in your area, contact your District Administrative Office.

A.R.S. § 41-3804
http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp

Membership in Human Rights Committees

Membership in a Human Rights Committee shall occur utilizing the following process:

A. Candidates for initial membership on a newly developed committee shall be recruited by the District Program Manager/Administrator with input and advice from the local chapter of The Arc, Developmental Disabilities Advisory Council and any other appropriate local advocacy organizations. The director of the Department of Economic Security shall appoint committee members from the list of candidates recruited locally.

B. Each committee shall be comprised of at least seven (7) and not more than fifteen (15) persons with expertise in one or more of the following areas:

1. Psychology.

2. Law.

3. Medicine.

4. Education.

5. Special education.

6. Parents of individuals with developmental disabilities.

C. No employee of the Department of Economic Security or of a service provider, which is associated with an existing Human Rights Committee, may be a voting member of a committee.

D. When there is a vacancy in an existing committee's membership, nominees may be presented to the committee by advocacy groups, committee members or the District Program Manager/Administrator. Upon recommendation by the committee by majority vote, the Department of Economic Security Director shall appoint a person to fill the vacancy.

303 Informed Consent

As one means of protecting the rights of consumers, the Division requires written consent from the individual/responsible person for release of confidential information. Consents may also be required for participation in events, medical treatments, and activities. A.R.S. § 36-551 (15) defines consent as voluntary informed consent. Consent is voluntary if not given as the result of coercion or undue influence.

Consent is informed if the person giving the consent has been informed of and comprehends the nature, purpose, consequences, risks and benefits of the alternatives to the procedure, and has been informed and comprehends that withholding or withdrawal of consent will not prejudice the future provision of care and supports and services to the individual. In case of unusual or hazardous treatment procedures performed pursuant to A.R.S. § 36-561, subsection A, experimental research, organ transplantation and non-therapeutic surgery, consent is informed if, in addition to the foregoing, the individual/responsible person giving the consent has been informed of and comprehends the method to be used in the proposed procedure.

All consents must be time or event-limited. Consent may be withdrawn at any time by giving written notification to the individual's Support Coordinator.

303.1 Consent to Medical Treatment of Adults

Incapacitated adults

An adult cannot consent to medical treatment if he/she lacks the understanding or capacity to make or communicate responsible decisions. One of the duties of a guardian is to make reasonable efforts to secure medical services for a member of the Division who is his/her ward. If a permanent guardian is unavailable (due to death, resignation, etc.), Arizona law allows other identified individuals to sign the consent for medical treatment of an incapacitated adult.

A. A.R.S. § 36-3231 defines surrogate decision makers priorities and limitations. In the following order of priority, these individuals may act as a surrogate to sign the consent for medical treatment of an incapacitated adult when no guardian is available.

1. The spouse of the incapacitated adult.

2. An adult child.

3. A parent.

4. A domestic partner (assuming the Member is not married and no other person has a financial responsibility for the individual).

5. A brother or sister.

6. A close friend. A close friend means an adult who has shown special care and concern for the individual, who is familiar with the individual's health care views and desires, and who is willing and able to become involved and act in the individual's best interest.

   A health care provider is required to make a reasonable effort to locate and follow a health care directive. A health care provider shall also make reasonable efforts to locate the above designated individuals. In order to assist the reasonable efforts of health care providers, the Division Support Coordinators should have available, at all times, a complete list of the names, addresses and phone numbers of these designated individuals who may be contacted for purposes of signing a consent for medical treatment. A copy of the list may be provided to treating medical personnel, as necessary, to assist them in locating a person authorized to sign the consent for medical treatment if a guardian is unavailable. If none of these persons is available, the appointment of a public fiduciary by the court may be requested.

B. A guardian has authority to execute the consent. If the guardian has executed a health care power of attorney that authorizes another

person to make health care decisions on behalf of the incapacitated person, the person named in that power of attorney has authority to execute the consent. The power of attorney is valid for not more than 6 months.

C. In an emergency, if time allows, a temporary guardian may be appointed by the court to sign a consent for medical treatment or the court may immediately exercise the power to consent to medical treatment prior to notice and hearing. If no one is available to serve as a temporary guardian, the court may appoint a public fiduciary.

D. When an immediate, life threatening emergency exists and there is neither time to get to court nor time to contact the individuals who may lawfully sign a consent, an attending physician, after consultation with a second physician, may make the health care treatment decision without a signed consent.

E. The Division Support Coordinators cannot sign a medical consent for treatment of incapacitated adults.

A.R.S. § 14-5101
A.R.S. § 14-5104
A.R.S. § 14-5310
A.R.S. § 14-5312
A.R.S. § 14-5602
A.R.S. § 36-3231

http://www.azleg.state.az.us/ArizonaRevisedStatutes

F. A surrogate may make decisions about mental health care treatment on behalf of a patient if the patient is found incapable. However, a surrogate who is not the patient's agent or guardian shall not make decisions to admit the patient to a level one behavioral health facility licensed by the department of health services, except as provided in subsection E of this section or section 14-5312.01, 14-5312.02 or 36-3231. Subsection E: If the admitting officer for a mental health care provider has reasonable cause to believe after examination that the patient is incapable as defined in section 36-3231, subsection D and is likely to suffer serious physical harm or serious illness or to inflict serious physical harm on another person without immediate hospitalization, the patient may be admitted for inpatient treatment in a level one behavioral health facility based on informed consent given by any surrogate identified in subsection A of this section. The patient

shall be discharged if a petition for court ordered evaluation or for temporary guardianship, requesting authority for the guardian to consent to admission to a level one behavioral health facility has not been filed within forty-eight hours of admission or on the following court day if the forty-eight hours expires on a weekend or holiday. The discharge requirement prescribed in this section does not apply if the patient has given informed consent to voluntary treatment or if a mental health care provider is prohibited from discharging the patient under federal law.

Consumer's Competency Questioned

When a consumer's ability to make decisions about medical treatment/ procedures is questioned, the matter must be forwarded to the Division's Medical Director at central office for consideration.

303.2 Consent to Medical Treatment of Minors

The general rule is that the parent or guardian of a minor must provide written consent for medical treatment, however, Arizona law allows other individuals to provide consent to medical treatment of a minor when a parent or guardian is unavailable.

A. A Member may consent to the medical treatment of a minor if the Member has a properly executed power of attorney from the minor's parent or guardian delegating the power to consent to medical treatment. The delegation of power may be for not more than six (6) months.

B. If time allows, a temporary guardian may be appointed by the court to consent to medical treatment, but the authority of the temporary guardian is limited to six (6) months. Where no one is available to act as a temporary guardian, a public fiduciary may be appointed by the court.

C. In cases of emergency, where a parent or guardian cannot be located after reasonably diligent efforts, consent may be given by a person standing *in loco parentis* to the minor. *In loco parentis* means a person who takes the parent's place by undertaking temporary care and control of a minor in the absence of a parent. For example, this might be a person who is a relative, caregiver, or teacher of the minor.

D. If no one can be located who stands in loco parentis to the minor, a physician can determine that an emergency exists, and that a parent

or guardian cannot be located or contacted after reasonable diligent effort. The physician can then perform a surgical procedure on the minor if necessary to treat a serious disease, injury, drug abuse or to save the life of the minor.

E. As a general rule, the Division Support Coordinators cannot sign a medical consent for treatment of minors except for children in foster care.

A.R.S. § 14-5104
A.R.S. § 14-5207
A.R.S. § 14-5209
A.R.S. § 14-5503
A.R.S. § 14-5602
A.R.S. § 36-2271
A.R.S. § 44-133

http://www.azleg.state.az.us/ArizonaRevisedStatutes

304 Health Care Directives/ Advance Directives

AHCCCS policy requires the Support Coordinator to ask the adult member if he or she has an advance directive. There are three types of advance directives: (1) a health care power of attorney, (2) a living will, and/or (3) a pre-hospital medical care directive. If the member does not have an advance directive, the Support Coordinator will offer guidance on how the adult member may complete an advance directive.

304.1 Health Care Power of Attorney

A health care power of attorney is a written statement executed by an adult who has the capacity to make such decisions naming another person (surrogate) to make health care decisions if that adult cannot make or communicate his/her wishes. A valid health care power of attorney must meet the requirements set forth in:

A.R.S. § 36-3221 – Healthcare Power of Attorney; scope; requirements; limitations

A.R.S. § 36-3222 – Healthcare Power of Attorney; amendments

A.R.S. § 36-3223 – Agents; powers and duties; removal; responsibility

A.R.S. § 36-3224 – Sample Healthcare Power of Attorney

A.R.S. § 36-3231 – Surrogate decision makers; priorities; limitations

304.2 Living Will

A living will is a written document executed by an adult who has the capacity to make such decisions in order to control the treatment/decisions made on that adult's behalf. The living will must meet the requirements set forth in:

A.R.S. § 36-3261 – Living Will; verification; liability

A.R.S. § 36-3262 – Sample living will

304.3 Prehospital Medical Care Directive

A Prehospital Medical Care Directive is commonly known as a Do Not Resuscitate (DNR). A DNR is a document signed by an adult that includes a DNR order written by a physician indicating to health care providers, emergency medical system personnel, and, as provided in A.R.S. § 36-3251(L), direct care staff persons that the member signing the DNR, who had the capacity to make such decisions at the time of signing the document, does not want cardiopulmonary resuscitation (CPR) if that member suffers from a cardiac or respiratory arrest. A valid DNR must meet the requirements set forth in A.R.S. § 36-3251 – Prehospital Medical Care Directive.

304.4 Procedures

A. The Support Coordinator must offer/provide the member with a copy of the *Decisions about Your Health Care* pamphlet. The member/responsible person must sign an acknowledgment stating that he/she is in receipt of this pamphlet, or has refused the pamphlet. This acknowledgement is to be maintained in the member's case file.

B. Annually, the Support Coordinator must ask the member if he/she has any of the three advance directives. If the member has completed one or more of these documents, the Support Coordinator must ask the member to provide a copy of all of the documents for his/her case file The Support Coordinator must note the existence of an advance directive on the annual planning document. The Support Coordinator/member/family/provider agency shall provide a copy of any advance directive to the primary care physician. If a member moves the Support Coordinator/member/family/provider agency shall send a copy of any advance directive with the member.

C. If the member/responsible person does not have any advance directives, the Support Coordinator must tell the member/responsible person where to find information and encourage the member/responsible person to consult with his/her health care provider regarding advance directives.

D. Pursuant to A.R.S.§ 36-3251 (L), when the physician of the member who has a valid Prehospital Medical Care Directive has ordered hospice plan of care, a direct care staff person may comply with a Preshospital Medical Care Directive (commonly known as a DNR). "Direct care staff person" is defined in A.R.S. § 36-3251 (N)(1) as a person who is employed or contracted to provide direct care services pursuant to Title 36, Chapter 5.1.

E. The provider agency must have a policy in effect indicating whether the direct care staff is required to initiate CPR or whether they may follow the DNR in a situation when a member is on hospice, has a DNR, and is found without pulse or respirations. The provider agency's policy must comply with A.R.S. § 36-3251.

F. In All Situations:

1. Direct care staff persons will call 911 and start CPR until there is a licensed healthcare provider present to execute a current and known advance directive. If the member is on a physician-ordered hospice plan of care and has a properly executed Prehospital Medical Care Directive (DNR), the direct care staff may comply with the Prehospital Medical Care Directive (DNR).

2. Licensed healthcare staff (e.g., Medical Doctor, Registered Nurse, Licensed Practical Nurse, Emergency Medical System Personnel) will follow any advance directive when known.

3. Except in the case of a court-ordered DNR, the custodial parent of a minor or a legal guardian, if present, may choose to follow the advance directive or may choose to overrule it, and request CPR and 9-1-1. Staff will comply with the custodial parent or legal guardian's request, documenting that request as soon as possible after Emergency Medical System Personnel has taken over care of the member.

G. These procedures apply to DDD and contracted personnel.

H. If in doubt, call 9-1-1 and start CPR.

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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

A.A.C. R6-6-101
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.

<u>DD Only (DDD)</u>

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).

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.

<u>Annual Plans</u>

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 to 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 (ALTCS) 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 end dated 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.

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500 ELIGIBILITY

501 Overview

This chapter discusses the criteria for eligibility for services from the Division. It outlines the procedures to be used to apply for services and to determine whether the applicant is eligible to receive services from the Division. Also please be aware that effective September 21, 2006, A.R.S. §§ 36-551 and 36-581 prescribed a change in terms and definitions for the Division of Developmental Disabilities. The term "cognitive disability" shall replace the words "mental retardation" for this policy. This change in terms and definitions does not affect federally defined terms or titles of certain documents authenticated by copyright laws.

502 Requirements for Division Eligibility

A person is eligible to receive services, within available appropriations, from the Division if that person voluntarily applies, is a resident of Arizona, gives informed consent, cooperates with the Arizona Long Term Care System eligibility process, and meets established diagnostic and functional criteria. It is the responsibility of the applicant, with guidance from the Division as needed, to provide the Division with a full complete record of the applicant's developmental, educational, familial, health, histories, including all relevant and accessible reports of psychological evaluations completed for the applicant.

The specific criteria for each of these eligibility requirements are described in the subsections below.

502.1 Residency

A person is eligible to apply for services from the Division if such person is a bona fide resident of the State of Arizona.

A.R.S. § 36-559

Resident means a person who physically resides within the State of Arizona with the intent to remain. The person who would receive the services must be the resident except in the case of minors whose residency is deemed to be the same as that of the custodial parent(s). The residency requirement is not applicable to foster children who are placed pursuant to A.R.S. § 8-548 and federal law regarding the Interstate Compact on the Placement of Children (ICPC).

All applicants shall sign an affidavit stating current residency and intent to remain in Arizona and provide two forms of documentation.

502.2 Application Process

Application will be made in the manner and on the forms specified in this chapter. For children birth to age 6, it is the responsibility of the Support Coordinator to

ensure that all applications including the referral source are entered into FOCUS within 48 hours of the signing of the application by the responsible person.

Applicant means the responsible person who has applied for Division services. An applicant shall show written proof of Arizona residency by providing two of the following types of documents:

Rent or mortgage receipt, or lease in the applicant's name showing the residential address.

A. Non-relative landlord statement indicating the applicant's name and address as well as the landlord's name and address and telephone, if applicable.

B. Applicant's Arizona driver's license.

C. Applicant's Arizona motor vehicle registration.

D. Signed employment statement from applicant's non-relative employer.

E. Utility bill in the applicant's name indicating the applicant's address.

F. United States Post Office records which show the applicant's name and address.

G. A current city directory showing the applicant's name and address.

H. Certified copy of a spiritual/faith community record or enrollment record that indicates the applicant's current name and address.

I. Certified copy of a school record that indicates the applicant's current address.

J. If an applicant has made all reasonable efforts to obtain documented verification related to Arizona residency and has been unsuccessful, the affidavit signed by the applicant attesting to the applicant's present residence and intent to remain in Arizona shall be sufficient.

A.A.C. R6-6-405

The Application for Eligibility Determination form will serve as the affidavit attesting to residency.

Social Security Numbers

The Federal Privacy Act, 5 U.S. Code § 552a (1974) provides that a state agency cannot require, as a condition for receiving any right, benefit or privilege provided by law, the disclosure of an member's Social Security Number unless:

A. The records system predates 1975 and used Social Security Numbers as identifiers, or

B. It has received special permission from Congress to require a Social Security Number.

The Division of Developmental Disabilities does not meet either criteria and, therefore, cannot require an individual or family to disclose their Social Security Number.

An individual or family may voluntarily disclose their Social Security Number.

Consent for Application for Services

Application shall be made on the forms specified in this chapter. Such form(s) must be signed by the responsible person. No admission to services may be made for any person without the consent of the responsible person.

A.R.S. § 36-560(A) (D)

For persons age 18 or over, the responsible person is the individual, unless that person has been adjudicated legally incapacitated and a guardian established by court order, in which case the legal guardian is the responsible person.

For persons under the age of 18, the legally responsible person is the parent or a court appointed guardian. If the child is a dependent ward of the court, the Administration for Children and Families (ACYF) caseworker may sign the application if, after diligent efforts have been made and documented to contact the biological parent, it is determined that the parent is not available. For children between the ages of 14 to 18 who live in residential settings supported by the Division, the child must also sign the application unless the Support Coordinator determines that the child does not appear to be capable of giving voluntary informed consent.

An adult capable of giving consent may apply for services from the Division. If an adult applies for admission and reasonably appears to the Department to be impaired by developmental disabilities to the extent that he/she lacks sufficient understanding or capacity to make or communicate responsible decisions regarding his/her person, the Division will require that prior to receiving programs or services, the person have a guardian appointed or shall have had a judicial determination made that it is not necessary to appoint a guardian for such person.

A.R.S. § 36-560(E)

A.A.C. R-6-6-402

An adult applying for services will be presumed capable of giving consent unless there is a court order declaring the person is legally incapacitated or the person's records indicate a diagnosis of profound or severe cognitive/intellectual disability. Family members applying on behalf of an individual described as having profound or severe cognitive/intellectual disability will be advised to file for guardianship and that a referral to the county public fiduciary may be made if there is no relative able or willing to act on behalf of the person.

Responsible Person and Application

The responsible person as defined in A.R.S. §36-551 (36) shall:

A. Sign application provided by the Division.

B. Participate in face-to-face interview with a designated Department employee.

C. Show evidence that the applicant is a resident of Arizona.

D. Provide proof of the applicant's age, health insurance coverage for the applicant and the applicant's income.

E. Supply documentation of the developmental disability in conjunction with the application.

502.3 Cooperation with Arizona Long Term Care System (ALTCS) Eligibility Process

The Division shall inform the individual/responsible person of the eligibility requirement regarding application for the Arizona Long Term Care System (ALTCS), as described in this policy**.** The individual/responsible person shall cooperate with the ALTCS application process prior to receiving services from the Division. Applicants voluntarily refusing to cooperate in the ALTCS eligibility process, including re-determination, are not eligible for Division services. Voluntary refusal to cooperate will not be construed to mean that the applicant is unable to obtain documentation required for eligibility determination.

In situations of immediate and compelling need, short-term services may be provided to members with developmental disabilities who are in the process of ALTCS eligibility determination.

The responsible person shall sign the *Intake Application -3 Years and Older* form explaining loss of benefits due to voluntary refusal to cooperate in the ALTCS eligibility determination process. See Section 506 for policy and procedures regarding determination of potential eligibility for ALTCS.

A.R.S. § 36-559(B) (C)

A.R.S. § 36-560(C)

502.4 Diagnostic and Functional Criteria for Persons Age 6 and Above

Persons age 6 and above are eligible to receive services from the Division subject to appropriation, if they have a developmental disability pursuant to A.R.S. § 36-559 and R6-6-302.

"Developmental disability" is defined in A.R.S. § 36-551(18) as a severe, chronic disability which is attributable to cognitive disability, cerebral palsy, epilepsy or

autism; is manifest before age eighteen; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency.

"Manifest before age eighteen" as defined in A.R.S. § 36-551(31) means that the disability must be apparent and have a substantially limiting effect on a person's functioning before age eighteen. At least one of the four qualifying conditions identified in A.R.S. 36-551 (cognitive/intellectual disability, autism, cerebral palsy, and/or epilepsy) must exist prior to the individual's eighteenth birthday.

"Likely to continue indefinitely" as defined in A.R.S. § 36-551(30) means that the developmental disability has a reasonable likelihood of continuing for a protracted period of time or for life. According to professional practice, "likely to continue" in relation to Traumatic Brain Injury (TBI) occurring prior to age 18, means that the condition must continue to exist at least two years after the diagnosis was made.

Cognitive/Intellectual Disability

"Cognitive disability" as defined in A.R.S. § 36-551(13) means a condition involving subaverage general intellectual functioning and existing concurrently with deficits in adaptive behavior manifested before age eighteen and that is sometimes referred to as "intellectual disability".

"Subaverage general intellectual functioning" as defined in A.R.S. § 36-551 (40) means measured intelligence on standardized psychometric instruments of two or more standard deviations below the mean for the tests used.

A. Acceptable documentation of cognitive/intellectual disability is a psychological or psycho educational report prepared by a licensed psychologist, a certified school psychologist, or a psychometrist working under the supervision of a licensed psychologist or certified school psychologist. The psychologist must administer or supervise the administration of a reasonable battery of tests, scales or other measuring instruments which are culturally and linguistically appropriate and valid. The instruments used should be editions current for the date of testing. Tests must consider:

1. Other mental disorders as defined by the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM). (e.g., schizophrenia, attention deficit hyperactivity disorder, developmental learning disorders, substance abuse, and adjustment disorder).

2. Significant disorders related to language or language differences.

3. Physical factors (e.g. sensory impairments, motor impairments, acute illness, chronic illness, and chronic pain).

4. Educational and/or environmental deprivation.

5. Situational factors at the time of testing.

6. Tests, which provide multiple sub-test scores, require interpretation of the full array of test results including sub-scale and sub-test scores before arriving at a diagnosis.

7. In the presence of co-existing mental illness, the I.Q. scores in the range of cognitive/intellectual disabled must precede the onset of the mental illness in order for the individual to be eligible for services.

8. Psycho-educational evaluations from school psychologists that do not include a formal diagnostic statement regarding cognitive/intellectual disability may eventually contribute to the eligibility determination if the data in the educational record is consistent with the diagnosis of cognitive/intellectual disability per A.R.S. 36-551.

B. Examples of testing instruments typically accepted include the Wechsler Intelligence Scales (Wechsler Preschool and Primary Test of Intelligence, Wechsler Intelligence Scale for Children or Wechsler Adult Intelligence Scale), the Stanford-Binet, and the Kaufman Assessment Battery for Children. Generally, an intelligence quotient (IQ) of 70 (plus or minus the standard error of measurement for the test) or below on one of these tests equals two or more standard deviations below the mean.

C. Examples of testing instruments from which IQ equivalent scores are sometimes obtained but which cannot be used as the sole source for determining cognitive/intellectual disability include, the Peabody Picture Vocabulary Test, Raven's Coloured or Standard Progressive Matrices, Matrices Analogies Test, Wechsler Abbreviated Scale of Intelligence or assessments in which only portions of a Wechsler test are administered.

D. A complete psychological or psycho educational evaluation report includes a medical, social, and/or educational history, a summary of previous testing results, results of the evaluator's interview with and/or observations of the individual and results of the individual tests of the battery administered. Useful scales designed to quantify adaptive behavior include, the expanded form of the Vineland Adaptive Behavior Scales and the American Association of Mental Retardation's Adaptive Behavior Scales. Test scores alone are not a sufficient measure of adaptive behavior since most instruments are informant-based, rather than dependent upon direct observation of the individual, therefore, the most desirable assessment of adaptive behavior includes both standardized informant-based measures and direct observation of the individual in his or her natural settings of home, school or employment.

E. A report that contains only an IQ test score shall not be used as the sole source for documentation of cognitive/intellectual disability.

F. The presence of cognitive/intellectual disability is properly documented on Axis II in the diagnostic section of the psychological report, as defined by the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM). Axis II is the correct axis for cognitive/intellectual disability and personality disorders and the assignment of a cognitive/intellectual disability diagnosis to Axis II does not, in and of itself, imply that the cognitive/intellectual disability condition is secondary to any condition reported on Axis I.

G. Measured intelligence means individually administered tests of intelligence according to generally accepted diagnostic instruments.

H. If the available documentation is a psycho educational evaluation, the educational classifications of a child with Mild Mental Retardation (MIMR) and a child with Moderate Mental Retardation (MOMR) are equivalent to a diagnosis of cognitive/intellectual disability. The educational classification of a child with Mild Mental Retardation may be equivalent to a diagnosis of cognitive/intellectual disability; such situations may require review by the Division Assistant Director or designee.

Adaptive Behavior

"Adaptive behavior" as defined in A.R.S. § 36-551(1) means the effectiveness or degree to which the individual meets the standards of personal independence and social responsibility expected of the person's age and cultural group.

A. The best indicators of an impairment of adaptive behavior are the results of an appropriately administered, scored and interpreted comprehensive measure (related to communication, academic/vocational, level of leisure activities, etc.).

B. Conditions such as acute or chronic mental illness, behavioral disturbances, substance abuse, adjustment disorders, sensory impairments, etc, have been shown in clinical research to reduce the level of adaptive functioning. When these factors or other potentially influencing factors are present for an individual, the impact of the factor or factors on adaptive functioning should be fully discussed in the psychological report.

Cerebral Palsy

"Cerebral palsy" as defined in A.R.S. § 36-551(10) means a permanently disabling condition resulting from damage to the developing brain which may occur before, after, or during birth which results in loss or impairment of control over voluntary muscles.

A. Acceptable documentation includes an evaluation by a licensed physician indicating the presence of cerebral palsy. If the medical records contain a diagnosis of spastic Quadra paresis, hypotonia, atheotosis, and similar conditions but do not refer specifically to

cerebral palsy, there must be documentation to confirm the condition results from injury to the developing brain.

B. Unacceptable documentation of cerebral palsy includes muscular dystrophies, arthrogryposis, and muscular or skeletal conditions. Individuals who have acquired an impairment in control of voluntary muscles as a result of illnesses or traumatic brain injury occurring after age 6 are not eligible in the absence of other qualifying conditions.

Epilepsy

"Epilepsy" as defined in A.R.S. § 36-551(21) means a neurological condition characterized by abnormal electrical-chemical discharge in the brain. This discharge is manifested in various forms of physical activity called seizures.

A. Acceptable documentation of a diagnosis of epilepsy or seizure disorder must be determined by a licensed physician.

B. In the event that records of a neurological evaluation cannot be obtained, the Division Medical Director will review the available medical records to confirm a diagnosis of epilepsy or seizure disorder, if the diagnosis is determined by a licensed physician who does not specialize in neurology.

C. Persons with a history of febrile seizures or febrile convulsions in the absence of other qualifying diagnoses are not eligible for services from the Division.

Autism

"Autism" is defined in A.R.S. § 36-551(7) as a condition characterized by severe disorders in communication and behavior resulting in limited ability to communicate, understand, learn and participate in social relationships.

A. Acceptable documentation of autism must include a statement by, or evaluation from, a psychiatrist, a licensed psychologist, or developmental pediatrician with experience in the area of autism identifying a diagnosis of Autistic Disorder (DSM-IV Code 299.00).

B. Rarely, in older records, autism may also be called Kanner's Syndrome and/or early infantile autism.

C. While a diagnosis of Autistic Disorder is one of the criteria that must be met, the opinion of the psychiatrist or psychologist is not by itself final or binding without adequate documentation and support for the diagnosis and related functional impairment. The record should clearly support that the member meets the diagnostic criteria for Autistic Disorder (See DSM-IV diagnostic criteria, below).

D. Medical and/or psychological records that refer to "autistic tendencies," "autistic behavior", "autistic-like disorder" or an "autistic spectrum disorder" are insufficient to establish eligibility. Members age 6 and over who have a diagnosis of Pervasive Developmental Disorder, Pervasive Developmental Disorder, Not Otherwise Specified, Asperger's Disorder, or Childhood Disintegrative Disorder are not eligible.

E. If the records do not clearly and consistently establish that the person meets the diagnostic criteria for Autistic Disorder, the application for eligibility determination or re-determination shall be referred to the Eligibility Review Committee prior to an eligibility decision.

Diagnostic Criteria for 299.00 - Autistic Disorder (DSM-IV pp. 70-71)

A. A total of 6 (or more) items from (1), (2) and (3), with at least two from (1), and one each from (2) and (3):

1. Qualitative impairment in social interaction, as manifested by at least two of the following:

   i. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.

   ii. Failure to develop peer relationships appropriate to developmental level.

   iii. A lack of spontaneous seeking to share enjoyment, interests or achievements with other people (e.g. by a lack of showing, bringing, or pointing out objects of interest).

   iv. Lack of social or emotional reciprocity.

2. Qualitative impairments in communication as manifested by at least one of the following:

   i. Delay in or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime).

   ii. In individuals with adequate speech, marked impairment in the ability to sustain or initiate a conversation with others.

   iii. Stereotyped and repetitive use of language or idiosyncratic language.

   iv. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

   i. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

   ii. Apparently inflexible adherence to specific, nonfunctional routines or rituals

   iii. Stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole-body movements)

   iv. Persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder

Exemption from Eligibility

Persons diagnosed by a licensed psychologist as having a "learning disability" or as meeting the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) criteria for a Learning Disorder are not eligible for services from the Division of Developmental Disabilities.

Substantial Functional Limitations

"Substantial functional limitation" as defined in A.R.S. § 36-551(41) means a limitation so severe that extraordinary assistance from other people, programs, services, or mechanical devices is required to assist the person in performing appropriate major life activities.

In addition to a diagnosis of cognitive/intellectual disability, cerebral palsy, epilepsy, or autism before age 18, documentation must verify substantial functional limitations attributable to one of the qualifying diagnoses in at least three of the following major life activities:

A. SELF-CARE:

   Self-Care means the performance of personal activities that sustain the health and hygiene of the individual appropriate to his/her age and culture. This includes bathing, toileting, tooth brushing, dressing, and grooming.

A functional limitation regarding self-care is defined in R-6-6-302 as when a person requires significant assistance in performing eating, hygiene, grooming or health care skills, or when the time required for a person to perform these skills is so extraordinary as to impair the ability to retain employment or to conduct other activities of daily living.

Acceptable documentation of limitations in this area include, self-care goals and objectives on a child's Individualized Education Program (IEP), relevant comments in a psychological or psycho educational evaluation, or relevant scores on the Arizona Long Term Care System (ALTCS) Preadmission Screening (PAS), or the Personal Living Skills section of the Inventory for Client and Agency Planning (ICAP) or other measures of adaptive functioning such as the Vineland Adaptive Behavior Scales or the Adaptive Behavior Assessment System.

B. RECEPTIVE AND EXPRESSIVE LANGUAGE:

Receptive and expressive language means the process of understanding and participating in conversations in the person's primary language, and expressing needs and ideas that can be understood by a person who may not know the person.

A functional limitation regarding receptive and expressive language as defined in R-6-6-302 occurs when a person is unable to communicate with others, or is unable to communicate effectively without the aid of a third person, a person with special skills, or without a mechanical device.

Acceptable documentation of limitations in this area includes; diagnosis in a psychological, psycho educational, or speech and language evaluation. Acceptable documentation can also be included in the child's Individualized Education Program (IEP) referencing severe communication deficits, the use of sign language, a communication board, or an electronic communication device. Relevant scores on the ALTCS PAS or the Social and Communication Skills section of the Inventory for Client and Agency Planning (ICAP) or other measures of adaptive functioning such as the Vineland Adaptive Behavior Scales or the Adaptive Behavior Assessment System, are also acceptable documentation for limitations with receptive and expressive language.

C. LEARNING:

Learning means the ability to acquire, retain, and apply information and skills.

A functional limitation regarding learning as defined in R-6-6-302 occurs when cognitive factors, or other factors related to the acquisition and processing of new information (such as attention factors, acquisition strategies, storage and retrieval), are impaired to the extent that the person is unable to participate in age-appropriate learning activities without utilization of additional resources.

Acceptable documentation of limitations in this area includes verification of placement in a special education program for persons with cognitive/intellectual disability.

D. MOBILITY:

Mobility means the skill necessary to move safely and efficiently from one location to another within the person's home, neighborhood, and community.

A functional limitation regarding mobility as defined in R-6-6-302 occurs when fine or gross motor skills are impaired to the extent that the assistance of another person or mechanical device is required for movement from place to place. Or when the effort required to move from place to place is so extraordinary as to impair ability to retain employment and conduct other activities of daily living.

Acceptable documentation of limitations in this area include, but are not limited to, documentation in the Inventory for Client and Agency Planning (ICAP), ALTCS PAS, medical, or educational records of the need to regularly use a wheelchair, walker, crutches, or other assistive devices, or to be physically supported by another person when ambulating.

E. SELF-DIRECTION:

Self-Direction means the ability to manage one's life.
Examples of managing one's life include:

1. Setting goals
2. Making and implementing plans to achieve those goals.
3. Making decisions and understanding the consequences of those decisions.
4. Managing personal finances.
5. Recognizing the need for medical assistance.
6. Behaving in a way that does not cause injury to self or others.
7. Recognizing and avoiding safety hazards.

A functional limitation regarding self-direction as defined in R-6-6-302 occurs when a person requires assistance in managing personal finances, protecting self- interest, or making independent decisions which may affect well-being.

Acceptable documentation of limitations in this area include, court records appointing a legal guardian or conservator; relevant comments in a psycho educational or psychological evaluation; relevant objectives in an Individualized Education Program (IEP); or relevant

scores on the Community Living Skills section of the Inventory for Client and Agency Planning (ICAP) or ALTCS PAS or other measures of adaptive functioning such as the Vineland Adaptive Behavior Scales or the Adaptive Behavior Assessment System. For children under the age of 18, the child's abilities in this area must be compared to what would normally be expected of a child of the same age who does not have a disability.

F. CAPACITY FOR INDEPENDENT LIVING:

Capacity for Independent Living means the performance of necessary daily activities in one's own home and community. This includes:

1. Completing household chores.

2. Preparing simple meals.

3. Operating household equipment such as washing machines, vacuums, and microwaves.

4. Using public transportation.

5. Shopping for food, clothing, and other essentials.

A function limitation regarding the capacity for independent living as defined in R-6-6-302 occurs when, for a person's own safety or well-being, supervision or assistance is needed at least on a daily basis, in the performance of health maintenance and housekeeping.

Acceptable documentation of limitations in this area include, relevant comments in a psycho educational or psychological evaluation; related objectives in an Individualized Education Program (IEP); relevant comments in a medical record; or relevant scores on the Personal Living Skills section of the Inventory for Client and Agency Planning (ICAP) or other measures of adaptive functioning such as the Vineland Adaptive Behavior Scales or the Adaptive Behavior Assessment System.

For children under the age of 18, the child's abilities in this area must be compared to what would normally be expected of a child of the same age who does not have a disability.

G. ECONOMIC SELF-SUFFICIENCY:

Economy self-sufficiency means the ability to independently locate, perform, and maintain a job that provides income above the federal poverty level.

A functional limitation regarding economic self-sufficiency as defined in R-6-6-302 occurs when a person is unable to perform the tasks necessary for regular employment or is limited in productive capacity

to the extent that earned annual income, after extraordinary expenses occasioned by the disability, is below the poverty level.

Acceptable documentation of limitations in this area include, but are not limited to, receipt of Supplemental Security Income (SSI) or Social Security Disability Income SSDI) benefits or eligibility for Vocational Rehabilitation services, or other measures of adaptive functioning such as the Vineland Adaptive Behavior Scales or the Adaptive Behavior Assessment System.

For children under the age of 18, the child's abilities in this area must be compared to what would normally be expected of a child of the same age who does not have a disability.

H. OTHER FACTORS TO CONSIDER IN DETERMING SUBSTANTIAL FUNCTIONAL LIMITATIONS

The Division will use a review process to determine whether an applicant, age 6 and above has substantial functional limitations in three or more of the seven life areas, the guide will consider:

1. Age of the person
2. Culture
3. Language
4. Length of time to complete task
5. Level and type of supervision or assistance needed
6. Quality of task performance
7. Effort expended to complete the task performance
8. Consistency and frequency of task performance
9. Impact of other health conditions
10. Quality of task performance

502.5 Criteria for Children Birth to Age 6

A child under the age of 6 years may be eligible for services if there is a strongly demonstrated potential that the child is or will have a developmental disability as determined by the appropriate tests. Developmental Disability is defined in Section 502.4.

In the absence of other qualifying circumstances, children with the following conditions are not eligible for services:

A. Congenital Heart Defect

B. Muscular Dystrophy

C. Orthopedic Disorders

D. Speech Delay Involving Only Intelligibility

E. Significant Auditory Impairment

F. Significant Visual Impairment

In accordance with R6-6-301 (F), to be eligible for Division services, a child birth to age 6 shall meet at least one of the following criteria:

A. Have a diagnosis of cerebral palsy, epilepsy, autism, or cognitive/intellectual disability.

B. There is a strong demonstrated potential that a child is or will have a developmental disability (i.e. the parent or primary caregiver has a developmental disability and there is likelihood that without early intervention services the child will have a developmental disability.) Children diagnosed with the following conditions may be at risk of a developmental disability:

1. Spina bifida with Arnold Chiari malformation

2. Periventricular leukomalacia

3. Chromosomal abnormalities with high risk for cognitive/intellectual disability such as Downs Syndrome

4. Autism Spectrum Disorders

5. Post natal traumatic brain injury such as "shaken baby syndrome" or near drowning

6. Hydrocephaly

7. Microcephaly

8. Alcohol or drug related birth defects such as Fetal Alcohol Syndrome

9. Birth weight under 1000 grams with evidence of neurological impairment

C. Have demonstrated a significant developmental delay based on performance on a norm-referenced or criterion-referenced developmental assessment that is culturally appropriate. This developmental assessment must also be a professionally accepted tool which indicates that the child has 50% delay in one of the following

five developmental domains or that the child has 25% delay in two or more of the following five domains:

1. Physical (fine and/gross motor, vision or hearing)
2. Cognitive
3. Communication
4. Social Emotional
5. Self Help

Developmental delay will be determined by a physician or person formally trained in early childhood development who evaluates the child through the use of culturally appropriate and recognized developmental tools and his/her informed clinical opinion.

Example: Child is 24 months old at testing

Test Results:

1. Cognitive - 18 months
2. Gross Motor - 23 months
3. Fine Motor - 23 months
4. Social/Emotional - 22 months
5. Adaptive/Self Help - 22 months
6. Communication - 18 months

In this example, the child has 25% delay in both cognitive and communication skills and is at risk of a developmental disability.

Examples of acceptable developmental evaluation tools include, but are not limited to, the Bayley Scales of Infant Development, the Battlle, and the Hawaii Early Learning Profile (H.E.L.P.).

Acceptable documentation of the potential that a child birth to age 6 is or will have a developmental disability includes, medical records indicating an at-risk condition, results of an acceptable developmental assessment, or a signed statement from a licensed physician, licensed psychologist, or other professional trained in early childhood development specifying his/her clinical opinion as to the child's disability or delay.

503 Referral Procedures

A. Referrals for Division services may be accepted from a variety of sources, including the applicant, the applicant's family, public schools, hospitals, or other state agencies such as the Arizona Long Term Care System (ALTCS), Child Protective Services (CPS), Adult Protective Services (APS), and Disability Determination Services (DDSA). Referrals may occur by phone, mail, or in person. The person receiving the referral should document the contact on the *Intake Record* form and ensure an intake worker is assigned according to local office procedures.

B. If the referral is from other than the applicant/responsible person, the intake worker should, within 5 working days, contact the applicant/responsible person, explain the Division's services and eligibility criteria, and determine if the responsible person wishes to apply for services. If the responsible person cannot be contacted by phone, a letter should be sent asking the responsible person to contact the intake worker within 10 days of the date of the letter if application is desired. If the responsible person wishes to apply for services, the intake worker will schedule an intake interview, which should occur within 10 working days of the date of initial contact with the responsible person. If the responsible person does not wish to apply, cannot be located, or does not respond, the intake worker will document the result and close the case.

C. All referrals for children in foster care will be completed through the district the CPS staff is located.

503.1 Intake Interview

The assigned intake worker will conduct the intake interview at the time and in the location mutually agreed upon during the initial contact with the responsible person. The intake process should include a face-to-face contact with the person for whom application is made.

For children birth through three years of age, the intake worker is encouraged to coordinate with the Arizona Early Intervention Program (AzEIP) initial planning process contractor to jointly visit with the family when possible.

The intake worker will complete the following during the intake interview:

A. *Application for Eligibility Determination* form

B. For persons age 6 and older, *Intake Application – 3 Years and Older* form

C. For persons age 6 and above, the *Inventory for Client and Agency Planning (ICAP).* Hard copies of this tool may be obtained in District offices

D. *Authorization for Release of Information* form in sufficient quantity to send to each school, social services agency, psychologist, physician, and hospital who has served the applicant and who may have records

needed to determine eligibility and/or plan appropriate services for the applicant. In particular, the intake worker will ensure that the Division requests copies of medical records such as hospital discharge summaries, specialist's consultation reports, and results of any significant medical tests.

E. Explain and provide a copy of, *Statement of Rights*, and obtain the signature of the responsible person on Form, *Acknowledgment of Publications/Information, Pre-PAS Screening Tool* form, and the *Application for the Arizona Health Care Cost Containment System (AHCCCS) Medical Benefits Part I*, are required for some members following determination of Division Eligibility (See Section 506). The intake worker may wish to complete these at the time of the intake interview

The intake worker should request copies of the following documents during the intake interview:

A. Court documents relating to guardianship, if appropriate.

B. Birth certificate.

C. Psychological evaluations, school records, medical records, or social service agency records applicable to determination of eligibility and/or identification of needs which may be in the possession of the individual/responsible person.

Prior to obtaining the responsible person's signature on the appropriate application and the *Authorization to Release Information* forms, the intake worker will explain:

A. Division eligibility criteria.

B. Confidentiality rights.

C. Requirement to cooperate with Arizona Long Term Care System (ALTCS) screening and application process.

D. Third party liability requirements.

E. Grievance and appeal rights.

F. Services available from the Division.

G. Services available from other agencies that might assist the applicant.

The intake worker will provide the applicant/responsible person with the following documents:

A. Mission and value statement,

B. Eligibility,

C. The DDD information booklet, *"Working With You"*.

503.2 Proof of Age

An applicant shall provide proof of age of the person to receive services by providing two of the following:

A. Citizenship documents.

B. Federal or state census records.

C. Hospital records of birth.

D. Copy of birth certificate.

E. School registration, if appropriate.

F. Military records.

G. Notification of birth registration.

H. Religious records showing age of date of birth.

I. Dated school records showing age or school records showing date of birth.

J. Affidavit signed by the licensed physician, licensed midwife, or other health care professional who was in attendance at the time of the birth, attesting to the date of birth.

K. U.S. passport.

L. If an applicant has made all reasonable efforts to obtain documented verification as described above and has been unsuccessful, the application signed by the applicant shall be sufficient to verify age of the person to receive services.

A.A.C. R6-6-402(A)

504 Eligibility Determination Process

Determinations or redeterminations of eligibility are subject to review at any time by the Division Assistant Director or designee.

A.A.C. R6-6-303

Following the intake interview, the intake worker will immediately mail the signed *Authorization for Release of Information* form to the applicable agencies and professionals in order to obtain needed medical, psychological, school, and social service records.

A. The Eligibility Clock:

Eligibility for all applicants should be determined within 60 days of the application date. If records required to complete the eligibility determination have not been received within 30 days of the application date, the applicant/responsible person should be notified by letter that records should be received within 30 days or the application may be denied, unless the child is eligible for the Arizona Long Term Care System (AHCCCS) or is age birth to three years.

There are two circumstances in which the eligibility clock is shorter, please refer to "B" and "C" below.

B. The Eligibility Clock for AzEIP (Children Birth to Three):

Eligibility for children birth through three years of age who are referred by or for AzEIP must be determined within 30 days and an initial Individualized Family Services Plan (IFSP) meeting held within 45 days of referral to AzEIP.

C. The Eligibility Clock for Initial Referrals Directly from AHCCCS:

Eligibility for initial referrals must be determined within 30 days of receipt of the initial referral when the referral source is Arizona Long Term Care System (ALTCS). If records required to complete the eligibility determination have not been received within 15 days of the referral date, the applicant/responsible person will be notified by letter that the records must be received within 15 days of the letter or the application will be denied.

The Division works with AzEIP who is responsible for the eligibility process.

Upon receipt of records, the intake worker will forward the entire intake file to the staff designated to make the eligibility determinations or redeterminations for that district/area. Designated staff will summarize the reasons for determination of eligibility or ineligibility with particular attention to describing functional limitations, when applicable.

Prior to determination or redetermination, the following types of situations shall be referred to the office of the Division Assistant Director or designee for specialized review and recommendation:

A. Traumatic brain injury occurring prior to age 18, in the absence of an appropriate rehabilitation history.

B. Pervasive developmental disorder, not otherwise specified or pervasive developmental disorder.

C. Asperger's Disorder, if there is question as to whether the person has a developmental disability as defined by Arizona statute.

D. Persons with an IQ in the cognitive/intellectual disability range who have an Axis I mental health diagnosis, if the diagnosis of a developmental disability as defined by Arizona statute is questionable.

E. Persons with a full scale IQ in the cognitive/intellectual disability range, if there is a difference of one or more standard deviations between the performance IQ and the verbal IQ and the diagnosis of a developmental disability as defined by Arizona statute is questionable.

F. Cerebral palsy diagnosed after the age of 6.

G. Rare degenerative conditions, if the diagnosis of a developmental disability as defined by Arizona statute is questionable.

H. Children under the age of 6 who have a significant medical disorder that impedes age appropriate functioning but the likelihood of developing one or the four developmental disabilities is unclear.

For these situations, the Division Assistant Director/designee shall ensure that all available records have been obtained and that the entire intake file is reviewed by the appropriate professional(s). The Division Assistant Director/designee shall maintain records regarding the disposition of each referral and identify trends in cases that are referred, coordinating the incorporation of this information into the Division ongoing eligibility training.

The date of eligibility shall be the date the person making the eligibility determination signs and approves the application form.

Upon eligibility determination, the intake worker or assigned district staff will update FOCUS and send notice of the decision to the applicant/responsible person. Written notice of ineligibility and intent to deny an application shall be issued by certified mail return receipt requested and shall include notice of appeal rights.

505 Assignment of Support Coordinators

Each person eligible for the Division is assigned a Support Coordinator. As part of the intake process, individuals/responsible persons will be informed of the option of choosing a Support Coordinator if a choice is available. Members who are currently eligible for services through the Division will be informed of the option of choosing a Support Coordinator as part of the Individual Support Plan/Individualized Family Services Plan (planning process.) Children in foster care will be assigned a Support Coordinator in the District the assigned CPS staff is located.

If the chosen Support Coordinator has a full caseload or is otherwise not available, the Support Coordinator Supervisor will attempt to match the member/responsible person with another Support Coordinator who has the skills and abilities the member/responsible person desires. The member/responsible person may also choose to be placed on a pending list for their first choice of Support Coordinator. If the member/responsible person chooses placement on a pending list, another Support Coordinator will be assigned in the interim. Support Coordinator Supervisors will ensure the members/responsible person is placed with the Support Coordinator of choice whenever possible.

Each person eligible for the Division will have a designated back-up Support Coordinator. If a member/responsible person/ contacts an office and the assigned Support Coordinator is not available, the person should be referred immediately to the back-up Support Coordinator for assistance.

In instances where a back-up Support Coordinator is not an option or is not available, the Support Coordination Supervisor will act as back-up. Whenever a change in Support Coordinator assignment is made, the member /responsible person must be notified of the change in writing and in advance of the change, whenever possible.

506 Re-determination of Eligibility

Reevaluation of eligibility shall be made prior to age 6. The Support Coordinator will ensure the Division file contains all current assessment and evaluation records and will forward the file to the Division Staff designated to complete eligibility determinations/redeterminations for the district/area. That staff will review these records to ensure the child continues to meet the eligibility requirements as outlined in Section 502 of this Manual. A new application form is not required at age 6. The results of the reevaluation will be documented in the Support Coordinator's progress notes and entered into Focus. If the reevaluation indicates that the child is no longer eligible, a Notice of Intended Action as referenced in the Grievance and Appeals section of this Policy Manual, shall be sent by certified mail, return receipt requested, to the responsible person.

Redetermination of eligibility shall also be made at age 18. The member/responsible person must sign an application form requesting continuation of services. The redetermination process shall follow the criteria and procedures outlined in Sections 502 through 504 above.

A reevaluation or redetermination may also be required at any time. For a child under the age of 6, as new information such as therapy, developmental, or psychological evaluations or updated medical records indicate that a strongly demonstrated potential that the child is or will become developmentally disabled no longer exists, a reevaluation of eligibility will be conducted.

Even though a person may at one time fully meet the Division's eligibility criteria, effective services may later reduce functional limitations to the extent they are no longer substantial. When in the opinion of the Division Assistant Director or designee, after a review pursuant to A.A.C. R6-6-301(E), it is necessary for a person to receive continued services to maintain skills or prevent regression; the person will remain eligible for services.

507 Determination of ALTCS Eligibility

Following determination of eligibility for services from the Division, newly eligible members shall be screened for referral to the Arizona Long Term Care System (ALTCS) unless the referral source was ALTCS. Persons who are identified from the

screening as potentially eligible for ALTCS shall not receive state funded Division services, except as outlined in Section 502.3, until the Arizona Health Care Cost Containment System (AHCCCS) determines the person is eligible or ineligible for ALTCS services.

A.R.S. §36-559(C)

Persons who meet the criteria for both the Resource Screening and the Functional Screening shall be referred to ALTCS.

507.1 Resource Screening for Arizona Long Term Care System (ALTCS)

The criteria for the financial screening are cash resources less than $2,000 and at least one of the following:

A. Receipt of Supplemental Security Income (SSI).

B. Eligible for Temporary Assistance to Needy Families (TANF), 6th Omnibus Budget Reconciliation Act (SOBRA), or other Medical Assistance (MA) categories.

C. Monthly income not to exceed 300% of the maximum Supplemental Security Income (SSI) benefit.

A child's income and resources will be considered in the eligibility determination. The income and resources of parents may be waived if the child would have been eligible to receive an ALTCS covered service within 30 days prior to the date of application for ALTCS.

The specific financial criteria used by ALTCS are extremely complicated. Whenever there is doubt about whether a person might meet ALTCS financial criteria, the member should be referred to ALTCS. Additional information regarding ALTCS eligibility is available in the ALTCS Eligibility Manual.

(http://www.azahcccs.gov/shared/Downloads/EligibilityManual/AEPM/ahcccseligibilitpolicymanual.htm)

507.2 Functional Screening for Arizona Long Term Care System (ALTCS)

The age appropriate Pre-PAS evaluation must be completed for all applicants, unless the referral source was ALTCS.

The Support Coordinator should explain to the members/responsible person that the Division may not be able to provide services, other than Support Coordination, to non-ALTCS eligible members, consequently, the members /responsible person may choose to apply for ALTCS, even though the Division is not making a referral.

507.3 Pre-Admission Screening (PAS)

The PAS is both a tool and a process used by Arizona Health Care Cost Containment System (AHCCCS) to determine medical/functional eligibility for the Arizona Long Term Care System (ALTCS) program.

The PAS tool compiles demographic, functional, and medical information for each ALTCS applicant. The PAS instrument measures the level of functional and medical disability and determines if the member is at risk of institutional placement. The PAS is administered by AHCCCS by a registered nurse and/or a social worker. Generally, responsibility for the completion of the PAS for persons served by the Division is as follows:

A. ALTCS nurse/social worker perform the PAS for members who are medically involved, including **all** persons who are dependent upon a ventilator, regardless of placement.

B. Nurses or social workers, as single assessors, may perform the PAS for members who reside in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), group home, developmental home or any Home and Community Based Services (HCBS) setting, who are not medically fragile or dependent upon a ventilator.

The PAS assessors have an ALTCS physician consultant available for physician review should there be a question of medical eligibility. ALTCS completes their eligibility process within a 45 day period for most applicants.

AHCCCS re-administers the PAS in rare situations. If the member is determined not ALTCS eligible, AHCCCS sends a file to the Division which is then distributed to the appropriate District for printing.

The Planning Team must use the PAS, along with the ICAP and other assessment information, to develop the Planning Document and substantiate the need for the services to be provided.

507.4 Arizona Long Term Care System (ALTCS) Referral Procedures

Members who meet both the financial and functional screening criteria will be referred to ALTCS by completion of the, *Application for Arizona Health Care Cost Containment System (AHCCCS) Medical Benefits Part I* form. The Support Coordinator shall assist the member /responsible person to complete this form and to take or mail it to the local ALTCS Eligibility Office.

The Support Coordinator will ensure the member /responsible person understands that the ALTCS eligibility process requires two steps: completion of the *Part II Application* via interview with an ALTCS Eligibility Worker and completion of the *Pre-Admission Screening (PAS)* evaluation, via an interview with an ALTCS nurse and/or social worker. ALTCS may also refer a member who is age 18 or over and not

receiving Supplemental Security Income (SSI) or Social Security Administration (SSA) benefits to Disability Determination Services to establish disability.

The Support Coordinator may serve as Authorized Representative for ALTCS only for those members who are not able to complete the application process independently and who do not have a family member or guardian readily available to serve as the Authorized Representative.

507.5 Arizona Health Care Cost Containment System (AHCCCS) Roster

The Support Coordinator must check, review and initiate the task assigned in FOCUS on a daily basis to determine if there are members newly eligible for Arizona Long Term Care System (ALTCS). If so, the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (ISP/Planning Documents) must be reviewed/developed in accordance with the timelines and procedures specified in this policy manual.

507.6 Appeal of Arizona Long Term Care System (ALTCS) Eligibility Decisions

The Division Support Coordinator may, upon request of the member or the responsible person, assist the member in completing forms and taking other procedural steps to appeal a denial of ALTCS eligibility.

508 Eligibility for the Arizona Early Intervention Program (AzEIP)

AzEIP defines as eligible a child between birth and 36 months of age who is developmentally delayed, or who has an established condition that has a high probability of resulting in a developmental delay.

A developmental delay is met when the child has not reached 50% of the developmental milestones expected at his/her chronological age in one or more of the following domains:

A. Physical (fine and/or gross motor, vision or hearing)

B. Cognitive

C. Communication

D. Social Emotional

E. Self-Direction

Developmental delay shall be determined by a person meeting the AzEIP personnel standards, such as a physician or person formally trained in early childhood development who evaluates the child through the use of culturally appropriate and recognized developmental tools. Eligibility shall be based on informed clinical opinion and parental input.

When a child is eligible for more than one AzEIP participating agency (Arizona State School for the Deaf and Blind, Division of Developmental Disabilities) the

Individualized Family Services Planning team makes the decision, based on the needs of the family and child which agency will perform the Support Coordinator function.

In order for a child who is AzEIP eligible to receive services through the Division, the child must also meet the Division eligibility criteria outlined in this chapter.

509 Eligibility Categories

There are three types of eligibility: State funded (DDD), Targeted Support Coordination (TSC), and Arizona Long Term Care System (LTC). Each type has a different mandatory minimum review cycle. Any member receiving services funded by the Division is required to follow the minimum requirements of service review and contact established by this policy manual.

A. Members who are DDD receive Support Coordination and direct services based on assessed need and availability of state funds. Members in this category have the right to choose the type of contact, as applicable. These members are not eligible for TSC or LTC.

   DDD Members have the right to choose the type of contact for required meetings. The types of contact include:

   1. In person

   2. By phone

   3. By email/mail

   Members who are in this category can select to be placed in Inactive Status after one year of eligibility. Members who select Inactive Status will be contacted by phone annually. For further information, contact the Support Coordinator.

B. Members who are TSC are eligible for Title XIX acute care services including, Early Periodic Screening Diagnosis and Treatment (EPSDT). Members in this category receive Support Coordination and direct services based on assessed need and availability of state funds. Members who are TSC are not eligible for LTC.

   Members who are TSC or their guardians have the right to choose the type and frequency of contact, as applicable. The member/responsible person may choose to change the type and frequency at any time.

   Members who are in this category have the right to choose:

   1. The type of contact:

      a. In person

b. By phone

c. By mail

2. The frequency of contact:

a. 90 days

b. 180 days

c. Annually

C. Arizona Long Term Care System

Members who are LTC eligible receive Support Coordination, direct services based on assessed need including medical necessity and cost effectiveness, and acute services including, EPSDT. Members eligible for LTC have a choice of a Division contracted health plan. Members in this category receiving services funded by the Division are required to follow the minimum requirements of service review and contact established by this policy manual.

510 Responsibilities of the Member/Responsible Person When Eligible for the Division

Responsibilities include but are not limited to:

A. Applying/re-applying for Arizona Long Term Care System (ALTCS).

B. Being available to meet for the required ISP/IFSP Planning Meeting and reviews.

C. Providing documentation for eligibility redetermination.

D. Reporting issues with providers of service including potential/suspected fraud and abuse.

E. Reporting changes of address.

F. Reporting major changes in member/family circumstances which may affect the provision of services.

G. Signing appropriate consents.

H. Providing appropriate receipts for Assistance to Families or Community Supported Living expenditures.

I. Providing appropriate documentation to obtain requested assistance from the Division.

J. Providing other documentation as requested by the Division (i.e., any changes in insurance policies with the effective date, third party liability information, burial insurance policies, etc.).

K. Complying with residential billing and cost of care requirements.

511 Inventory for Client and Agency Planning (ICAP)

The Division requires that the ICAP be completed by the Support Coordinator during intake and at redeterminations for members age 6 and over. The Support Coordinator may not delegate responsibility for completion of this evaluation to a provider or to the family. The ICAP is protected by copyright; photocopies of the response booklet may not be used in the administration of the evaluation.

The ICAP is a standardized assessment tool which provides information regarding the member's medical condition and diagnoses, motor skills, social and communication skills, personal living skills, community living skills, social and leisure activities, and problem behaviors, if any.

The information contained in the ICAP is to be used, in conjunction with the Pre-Admission Screening (PAS) tool and other assessment information, to develop functional statements of need in the Planning Document and to establish the necessity of the services to be provided.

The ICAP provides scores which can be used to determine the level of supervision a member needs.

The Support Coordinator will ensure that the ICAP score for each member is entered in Focus.

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600 SERVICES

601 Overview

This chapter describes each long term and acute care service provided by the Division. It further provides a description of each service including who, what, where, how and when of the service provision, the provider type and training required, and the service limitations and exclusions (non-Long Term Care Services covered services are available based upon the availability of state funds). It defines the delivery system for acute care services.

The Arizona Long Term Care System (ALTCS) provides funding for certain services based upon assessed needs and medical necessity. ALTCS does not provide day care or educational services. Transitional Waiver services include all Home and Community Based Services under ALTCS and supported employment. The Transitional Waiver is a program for members who were eligible for the Arizona Long Term Care System and have improved either medically, functionally or both to the extent that they are no longer at risk of institutionalization at a nursing facility or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)level of care. The Transitional Waiver does not cover institutional services in excess of 90 days.

Based on assessed need, the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) drives what services, 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 are, the best ways to meet those needs and what the primary caregiver(s) is willing and able to do. Often a person's services needs may be met through natural supports (such as relatives, friends, places of worship and local community resources). A contracted service provider may also be used. Though funding for services through ALTCS is not intended to replace what families currently provide, under certain circumstances parents or family members may be paid to provide services that support home and community living.

601.1 Family Members As Paid Providers

In some situations, family members may be paid to provide certain services. Immediate relatives permitted to provide service include the following:

A. Natural Child

B. Natural Sibling

C. Adoptive Child

D. Adoptive Sibling

E. Stepchild or Stepsibling

F. Father-in-Law, Mother-in-Law, Son-in-Law, Daughter-in-Law, Sister-in-Law, Brother-in-Law

G. Grandparent or Grandchild

H. Spouse of Grandparent or Grandchild

Immediate relatives not permitted to provide services for children under age 18 include:

A. Natural Parent

B. Adoptive Parent

C. Step Parent

Certain requirements are specific to family members who may be paid to provide supports to their family member with a developmental disability. They include:

A. Parent/Step Parents may only be paid for an adult child (over age 18). Other family members of an adult or minor who meet certification requirements may be paid to provide services.

B. A spouse of a person with a developmental disability may not be paid to provide services to their spouse. (See Attendant Care section for exception.)

C. The Planning Team must determine the type and amount of services the person needs within their home environment. This determination is based on assessed need as well as the availability of natural and community resources.

D. Family members cannot be paid for skilled care during the provision of services such as Attendant Care or habilitation (skilled care includes but is not limited to: G-tube insertion and feedings, catheter replacement, respiratory treatment such as Small Volume Nebulizers or suctioning tracheostomy care. (See Appendix D – Skilled Nursing Matrix.).

E. A single family member who is an individual independent provider may not be paid to provide more than 40 hours of any combination of service per week. This maximum of 40 hours per week does not limit another family member from providing services. For example, an adoptive sibling may provide 38 hours of services and the grandparent may provide another 12 hours of service.

F. Family members must comply with all requirements in their contract in addition to all policies, procedures, laws and rules.

G. Primary caregivers/parents may not be paid to provide Respite.

H. Services shall not replace care provided by the person's natural support system.

I. Family members shall participate in and cooperate with ongoing monitoring requirements by the Division.

J. Qualified family members may become certified home and community based services providers by meeting the certification requirements, as applicable.

K. When a family member requests to become the provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.

Home and Community Based Service Delivery

Member directed service options allow members to have more control and flexibility over how some of their services are provided. The options are not a new service, but rather a way of providing services which offers the member the ability to play a more active role in directing their own care. Member directed service options are available to Arizona Long Term Care System (ALTCS) members who live in their own home.

Traditional

Traditional is a way of providing Home and Community Based services which offers members the ability to select a Qualified Vendor.

Agency with Choice

Agency with Choice is a way of providing Attendant Care (ATC), Homemaker (HSK) or Habilitation (HAH/HAI) services which offers members the ability to play a more active role in directing their own care. The Agency with Choice service option allows ALTCS members living at home to enter into a co-employment relationship with the provider agency. This gives the member more control over assigning duties and schedules for the caregiver but leaves the hiring, firing, and minimal training requirements as the responsibility of the provider agency.

If a member is unable to fulfill the co-employment roles and responsibilities for the above listed services on their own, an Individual Representative may be appointed to assist them in directing their care. If a member has a legal guardian, that guardian automatically serves in the capacity of an Individual Representative. The role of an Individual Representative is to act on the member's behalf in choosing and directing care, including representing the member during the service planning process and approving the service plan. Arizona Administrative Code Title 9, Chapter 28, Section 509 (A.A.C. R9-28-509) and Section 1915 (k) of the Social Security Act prohibit an Individual Representative from serving as a member's paid Direct Care Worker.

Individual Independent Providers

Individual Independent Providers is a way of providing Attendant Care (ATC), Homemaker (HSK), Respite and Habilitation (HAH/HAI) services which offers members and their families the ability to direct their care. This gives the member control over assigning duties and schedules for the direct care worker including hiring, firing, and minimal training requirements. The member/responsible person

must enroll with the Division's Fiscal Intermediary agency as the employer of record. The member or responsible person can change individual independent providers at any time. This method of service delivery mainly differs from Traditional and Agency with Choice in that the member does not have to choose a direct care worker employed by a Qualified Vendor to deliver these services.

602 Services

The following section contains information about services available either through the Arizona Long Term Care System (ALTCS) or the State only funded programs administered by the Division. Each eligible member will receive services in accordance with documented needs and availability of State funds.

Although the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan processes identifies needed services, members who are eligible for ALTCS shall receive information regarding their right to receive services as authorized.

Members who are eligible for ALTCS shall also receive information regarding the appropriate Division staff to contact if services are not provided as scheduled. The Support Coordinator must assess with the member their needs, the risk to the member if a gap in services were to occur and develop a contingency plan in the event of a services gap. These needs and risk factors are determined at the time of the initial and quarterly (90 day review) assessments. The Support Coordinator shall also explain the guidelines regarding the Divisions process (including a time estimate) for providing services when there is a service gap. The Division tracks and trends these gaps in services per the Arizona Health Care Cost Containment Systems (AHCCCS) contract requirements. The Division also submits a semi-annual report and other necessary reports to the AHCCCS summarizing trends, services gaps and related grievances.

Primary care givers are not required to be in the home during the delivery of services unless one of the following situations exists:

A. The primary care giver provides "skilled care" and the service being provided is non-skilled care. In this case, the primary care giver would need to perform any "skilled care" that the provider is not certified/licensed to do.

B. The intent of the service as documented on the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) is to facilitate the primary care giver's ability to work with the member. As an example, the service is intended to directly train the family in learning how to respond to behavior problems.

Each person must be evaluated on a member basis to determine medical necessity as well as the least costly level of care that will achieve the desired results.

Only nurses or respiratory therapists can provide skilled care. For example, skilled care includes Jejunum tube insertion, catheter replacement, respiratory treatment such as Small Volume Nebulizers suctioning, tracheostomy care etc.

Guidelines for services and evaluation criteria are found in the Service Approval Matrix (Prior Authorization). This information is available on the Division's website. https:/www.azdes.gov/main.aspx?menu=96&id=2470

The source information regarding each service is found in one of the following documents:

A. Chapter 42 Code of Federal Regulations. www.gpo.gov

B. AHCCCS Medical Policy Manual. www.azahcccs.gov

C. A.R.S. §36. www.azleg.gov/ArizonaRevisedStatutes.asp

D. The Division Service Specifications.

602.1 Assisted Living Centers

Description

"Assisted Living Center" (Center) means an assisted living facility that provides resident rooms or residential units to eleven or more residents. Assisted Living Centers may be licensed to provide one of three levels of care listed below, as defined by the Arizona Department of Health Services:

"Supervisory care services" means general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis and assistance in the self-administration of prescribed medications.

"Direct care services" means programs and services, including personal care services provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions.

"Personal care services" means assistance with activities of daily living that can be performed by persons without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medication and treatments by a nurse who is licensed pursuant to Arizona Revised Statutes Title 32, Chapter 15 or as otherwise provided by law.

Considerations

To ensure the appropriateness of a placement in a Center, the following must be considered and documented:

A. The member is over the age of 60; however, the team can recommend exceptions for approval by the Assistant Director.

B. A nursing home is the only other alternative available or the team feels a Center best meets the needs, desires, and capabilities of the member.

C. Alternate placements were considered and the reason why they were not appropriate. Center placement cannot be the only placement option considered and cannot be used as an "emergency" placement alternative.

D. The member and/or guardian clearly understand the alternative placement options.

E. The guardian, member, and the Support Coordinator have visited the proposed center.

F. The member will be placed with a similar age group as the other members living in the Center and not be segregated based on disability.

G. The supports identified in the Individual Support Plan/Person Centered Plan can be provided by the Center.

H. The member must be given the choice to live by with or without a roommate. The Support Coordinator shall document this choice on the *Assisted Living Center/Single Occupancy Form*. This form shall be filed with the Planning Document and be reviewed annually. At any time the member may contact their Support Coordinator to revise their choice to live with or without a roommate. When this occurs the Support Coordinator shall update the form.

I. The Support Coordinator and others can monitor the Center at any time. Monitoring by the Support Coordinator, through on site visits, will be conducted at least every 30 days for the first quarter and every 90 days thereafter.

J. The District Program Manager/designee has reviewed the required documentation and concurs the considerations has been met prior to the authorization of services.

Conditions

When identifying potential Centers, the following conditions are recommended:

A. Private room (unless the member chooses to have a roommate as noted above).

B. Room includes a private in-room bathroom (unless the member chooses to have a roommate as noted above).

C. Space allows for separation of sleeping and living areas.

D. An inside door lock.

E. Food preparation space.

F. Doorbell or door knocker.

G. Individual mailbox.

H. Variety of on-site and off-site and events from which to choose.

I. Transportation.

J. Indoor and outdoor common areas.

K. Weekly housekeeping service.

L. Weekly laundry service.

M. Monthly newsletter or calendar of events.

Exclusions

Under no circumstance will an Assisted Living Center /Assisted Living Facility be used for Respite.

602.2 Attendant Care

Description

This service provides assistance for a member to remain in their home and participate in community activities by attaining or maintaining personal cleanliness, activities of daily living, and safe and sanitary living conditions.
Barring exclusions noted in this section, Attendant Care may include the following as determined by the member's assessed needs:

A. Meal preparation and clean up (e.g., meal planning, preparing foods, special diets, clean-up, and storing foods).

B. Eating and assistance with eating.

C. Bathing (e.g., washing, drying, transferring, adjusting water and setting up equipment).

D. Dressing and grooming (e.g., selecting clothes, taking off and putting on clothes, fastening braces and splints, oral hygiene, nail care, shaving and hairstyling).

E. Toileting (e.g., reminders, taking off and putting on clothes and/or undergarments, cleaning of catheter or ostomy bag).

F. Mobility (e.g., physical guidance or assisting with the use of wheelchair).

G. Transferring.

H. Cleaning.

I. Laundry (e.g., putting clothes in washer or dryer, folding clothes, putting away clothes).

J. Shopping (e.g., grocery shopping and picking up medications).

K. Attending to certified service animal needs.

L. General supervision for a member who cannot be safely left alone. (See Appendix A, B and C.)

Responsible Person's Participation (Attendant Care)

The member/family is responsible to provide:

A. Needed supplies (e.g., cleaning supplies) or money for supplies. Money must be provided in advance when the Attendant Care provider is expected to shop for food, household supplies, or medications.

B. Documentation required for the approval of this service.

Considerations (Attendant Care)

When assessing the need for this service, the following factors will be considered:

A. Due to advancing age, a temporary or permanent documented physical or cognitive/intellectual disability or documentation of other limitation, the parent or guardian cannot meet a child's basic care needs.

B. Due to the child's intensive medical, physical, or behavioral challenges, which are a result of the disability, the parent or guardian cannot meet the child's care needs.

C. The child, due to a medical condition or procedure related to the disability, is unable to attend their school/work/day program, and natural support(s) is/are unavailable to provide care.

D. The adult member is unable to meet specific, basic personal care needs.

E. The adult member lives alone and is temporarily unable to meet basic personal care needs due to a medical condition or illness.

F. The member's needs are not currently met due to unavailability of service. Attendant Care may be used as an alternative service.

G. The member has medical or physical needs, was living in a Developmental Home, Group Home, Intermediate Care Facility (ICF), Nursing Facility, or other out of home placement, and with Attendant Care, the member will be able to return home.

H. When a spouse provides Attendant care, the total hours of Attendant care may not exceed 40, regardless of who provides the care. In addition, the member may not receive any similar or like service (i.e., Homemaker). (Habilitation services are not a similar or like service.)

I. Attendant care services are subject to monitoring and supervision as outlined in Arizona Health Care Cost Containment System policy.

J. When a family member requests to become the Attendant care provider for a member over the age of 18, the Support

Coordinator/designee will conduct a personal interview with the member.

Settings (Attendant Care)

Attendant Care Services may only be provided:

A. In the member's home (unlicensed).

B. In an Independent Developmental Home when there is a specific issue, problem, or concern that is believed to be temporary or short term and the service is approved by the Assistant Director/designee.

C. In the community:

1. While accompanying the member; or,

2. While shopping or picking up medications.

Exclusions (Attendant Care)

Exclusions to the authorization of Attendant Care Service are indicated below. Exceptions shall be approved by the District Manager.

A. The Attendant Care Service:

1. Shall not substitute for private pay day care or a school program for children.

2. Shall not cover before and after school care needs, days when there is no school, half school days, holidays, or summer and winter breaks or for 'babysitting' unless a child meets the criteria for supervision.

3. Shall not be provided for acute illnesses that prevent the child from attending private daycare or school.

4. Shall not be provided while the member is hospitalized.

5. Shall not substitute for Work, Day Program, Transportation, or Habilitation unless those services are not available to the member.

i. When used as a substitute, Attendant Care shall be used only until an appropriate service is available.

ii. When the appropriate service has been refused, Attendant Care cannot be used as a substitute.

6. Shall not substitute for Respite.

7. Shall not be received during the provision of a Division funded Employment or Day Program.

8. Shall not be used to avoid residential licensing requirements.

9. Shall not be used to take the place of care provided by the natural support system for children.

B. The tasks below are not included as part of the Attendant Care Service:

1. Cleaning up after parties (e.g., family celebrations and holidays).
2. Cleaning up several days of accumulated dishes.
3. Preparing meals for family members.
4. Routine lawn care.
5. Extensive carpet cleaning.
6. Caring for household pets.
7. Cleaning areas of the home not used by the member (e.g., parents' bedroom or sibling's bathroom).
8. Skilled medical tasks. (See Appendix D – Skilled Nursing Matrix.)
9. Shopping for a child living in the family home.

C. The Division will not authorize Attendant Care when the only tasks identified are cleaning, shopping and laundry. (See Homemaker section in this chapter.)

602.3 Day Treatment and Training

602.3.1 Service Description and Goals (Day Treatment and Training)

This service provides specialized sensory-motor, cognitive, communicative, behavioral training, supervision, and as appropriate, counseling, to promote skill development in independent living, self-care, communication and social relationships.

The goals of this service are to:

A. Increase or maintain the self-sufficiency of eligible members.

B. Improve emotional and mental well-being.

C. Enable eligible members and their families to acquire knowledge and skills.

D. Ensure the availability to eligible members of information about and access to human services and community resources.

E. Develop positive relationships with and support for families.

F. Encourage family and member participation in areas of the program.

G. Recognize and acknowledge that the members (and families, if guardians) are the main decision makers in the delivery of service.

H. Ensure that programs optimize the health and physical well-being of the members served.

I. Provide opportunities for members to participate in meaningful community activities.

J. For early intervention, to partner with families to support the parent-child relationship as the primary relationship in the context of naturally occurring routines and activities the family identifies as priorities.

K. Produce outcomes of increased individual skill development toward Individual Support Plan/Individualized Family Services Plan/Person Centered Plan member and family goals.

L. Assist members in achieving and maintaining a quality of life that promotes the member's vision of the future.

602.3.2 Service Settings (Day Treatment and Training)

Early intervention services for children age birth to 36 months of age and their families are provided in natural environments including the home and community settings in which children without disabilities participate. All other Day Treatment and Training may be provided in any setting and including during the school year and summer vacation. Day Treatment and Training may not be provided in an ICF/IID, child or adult developmental home or group home.

602.3.3 Service Requirements (Day Treatment and Training)

Before Day Treatment and Training can be authorized, the following requirements must be met:

A. The Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) must identify needs and outcomes consistent with the service description and setting.

B. Training and instruction must be pertinent to the present developmental, physical, mental and/or sensory abilities of the member.

602.3.4 Target Population (Day Treatment and Training)

Using the assessment and plan development processes described in in this policy manual, the Planning Documents must determine the need for this service according to the following age categories:

A. Birth - 36 Months of Age.

Day Treatment and Training is appropriate when the family's concerns, priorities, and resources identify that the developmental needs of their child would best be met by these supports.

B. Age 36 Months - 5 Years of Age.

Generally children of this age range will receive this service from public schools in accordance with Part B of Public Law 105-17, (www.gpoaccess.gov/plaws/) however, the provision of Day Treatment and Training by the Division may be appropriate, in some instances, if all of the following conditions are met:

1. The Planning Document identifies needs above and beyond those identified in the Individualized Educational Plan.
2. The additional hours of Day Treatment and Training would be reasonable and normal for the child's age considering the number of hours the child is participating in pre-school programs and other out-of-home activities.
3. The child's developmental needs can best be met in a group setting.
4. Family and other community resources are not available to meet the need.
5. No other service is more appropriate.

C. Age 5 - 12 Years of Age.

Generally, children with developmental disabilities will have their need for this service met by the public school system, therefore, most children will not need nor receive Day Treatment and Training during periods of time they are eligible for public education services.

Arizona Health Care Cost Containment System (AHCCCS) does not pay for child care or Respite as an alternative to Day Treatment and Training services for children 5 to 12 years of age. The provision of Day Treatment and Training by the Division may be considered for this age group if all the requirements for the 3 - 5 years age group are met and if the child needs to develop appropriate social and behavioral interaction skills and opportunities to integrate with non-disabled peers. If the Division considers Day Treatment and Training services for children 5 – 12 years of age, habilitation goals and objectives must be established and documented in the Individualized Family Services Plan/Person Centered Plan/Child and Family Team Plan.

The Division may also consider providing Day Treatment and Training services when the member is eligible for the Extended School Year Program. This may indicate a need for Day Treatment and Training to be provided in the summer. Habilitation goals and objectives must also be documented in the respective plans (referenced in "c" of this section) for Day Treatment and Training services for the summer.

D. Age 13 - Graduation from High School (18 - 22 Years of Age.)

Generally, members with developmental disabilities will have their need for this service met by the public school system, therefore, most

members will not need nor receive Day Treatment and Training during periods of time they are eligible for public education services. The provision of Day Treatment and Training by the Division may be considered for this age group if all the requirements for the 3 - 5 years age group are met. In addition, the Support Coordinator must determine that community resources are unavailable to meet skills identified in the Service Description and Goals Section, especially as related to independent living, communication and social relationships. If the Division considers Day Treatment and Training for this age group, habilitation goals and objectives must be established and documented in the Individual Support Plan/Person Centered Plan.

E. Adults

Day Treatment and Training should enable members to increase their range of independent functioning and to refine their personal living skills. The service shall be age appropriate.

Members participating in Day Treatment and Training may also participate in Employment Supports and Services as part of a meaningful day.

602.3.5 Exclusions (Day Treatment and Training)

Exclusions include to the provision of Day Treatment and Training shall not:

A. Substitute for Respite or day care.

B. Be used in place of regular educational programs as provided under Public Law 105-17. (www.gpoaccess.gov/plaws/)

C. Be used to provide other related services that have been determined in the Individualized Education Plan to be educationally necessary.

D. Be used when another service, such as an employment service, is more appropriate.

E. Include wage-related activities that would entitle the member to wages.

602.3.6 Service Provision Guidelines (Day Treatment and Training)

Utilization of Day Treatment and Training will be in accordance with the Individual Support Plan/Person Centered Plan (Planning Documents).

602.3.7 Provider Types and Requirements (Day Treatment and Training)

Designated District staff will ensure that all contractual requirements related to Day Treatment and Training providers are met before services can be provided. Additionally, all providers of Long Term Care Services must be certified by The

Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.3.8 Service Evaluation (Day Treatment and Training)

The Support Coordinator must continually assess the quality of services provided to members with developmental disabilities as defined in the mission statement. In addition:

A. The provider must submit a written progress report on Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents) outcomes as required by the Division's Provider Manual Progress Reporting Requirement, to the Support Coordinator. The report must address the presence or absence of measurable progress toward the member's goals and outcomes. On a monthly basis, the Support Coordinator must review these reports for progress toward outcomes. If there is no progress in the time period specified, the member with their Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Team) must reassess the outcomes and determine the on-going appropriateness of the service or outcome.

B. The Support Coordinator must perform a review of the Planning Documents as noted in this policy manual.

C. The provider must maintain a monthly activity schedule based on the goals and preferences of the persons' supported.

D. Materials, supplies and equipment used to deliver Day Treatment and Training must be furnished by the program and meet the needs of the member and be age appropriate.

602.3.9 Service Closure (Day Treatment and Training)

Service closure should occur in the following situations:

A. Based on the member's progress, the Planning Documents should determine when goals have been met and the service terminated.

B. The member/responsible person decline the service.

C. The member moves out of state.

D. The member transitions to another age/skill appropriate service or program.

E. The member/responsible person/family can now meet the needs the service addressed, as identified in the Planning Documents.

A Notice of Intended Action must be sent in accordance with the processes defined in this manual.

602.4 Employment Related Programs

602.4.1 Service Description and Settings (Employment Supports and Services)

These services provide opportunities for employment using several models to support members in a variety of job related settings.

A. Individual Supported Employment provides job coaching contacts at an integrated community job site with the employed member and/or employer. This service is to help ensure that the member maintains employment. Individual Supported Employment may also include job search services if these services are not available through Vocation Rehabilitation.

   Members receiving this service must not be a part of an enclave or work crew and must be paid by the employer. Individual Supported Employment is a time-limited service shall be provided on a member basis and can be used for members who are self-employed.

B. Group Supported Employment is a service that provides members with an on-site supervised, paid work environment in an integrated community setting. Settings may include enclaves, work crews, and other integrated work sites.

C. Center Based Employment is a service that provides members a healthy, safe and supervised work environment. This service is provided in a Qualified Vendor owned or leased setting where the majority of the members have disabilities and are supervised by paid staff. The service goal is to provide members with gainful, productive, and remunerative work.

D. Transition to Employment is a service that provides individualized and time-limited instruction, training and supports to help the member achieve the employment-related outcomes in the member's planning document. Through the use of a Division approved curriculum, including unpaid work exploration and job shadowing opportunities, the provider will assist the member to develop positive work habits, attitudes, skills, and work etiquette. Members receiving this service are expected to gain and demonstrate job readiness skills and be referred for integrated and competitive employment upon completion.

E. Employment Support Aide services provide members with the one-to-one supports needed to enable them to remain in their employment. These supports can include personal care services, behavioral intervention, and/or "job follow along" supports, and may be provided in any of the above service settings, as well as a stand-alone service.

F. Split Programming may be appropriate for members who desire to participate in multiple employment supports and services. These services are billed hourly and based on team agreement and assessed need. Split programming is designed to fulfill the needs and desires of the members. Members participating in Day Treatment and Training may also participate in Employment Supports and Services as part of a meaningful day.

602.4.2 Transportation Services for Employment Related Programs

Transportation to and from work may be available to members receiving Employment Supports and Services, when such transportation is not available from community resources or natural supports.

602.4.3 Target Populations (Employment Supports and Services)

Members who may benefit from supported employment as determined by the Planning Team (Individual Support Plan/Person Centered Plan team).

The Individual Support Plan/Person Centered Plan meetings and monthly progress reports from providers may be used as a means to identify the need for employment services. Participation in Individual Employment Plan meetings/School-to-Work Transition Planning meetings and the member's verbalized interest in employment may also identify the member's need for employment services.

The member with their Planning Team (Individual Support Plan/Person Centered Plan team) identifies the member's desires and dreams, employment goal and prior work history. In addition the role of the Planning Teams includes a description regarding the level of support needed and documentation of these needs (including transportation) on the Individual Support Plan/Person Centered Plan.

Employment Supports and Services are available to members who are eligible for Arizona Long Term Care Services based on assessed need, and to State-funded only members based on assessed need and availability of funding.

602.4.4 Service Requirements and Referral Process (Employment Supports and Services)

The Support Coordinator completes a Request for Employment Supports and Services packet when the Planning Team determines that a member may benefit from an employment related service.

This packet is then submitted to the Employment Program Specialist. The service code "VRI" shall be entered into the Focus system as part of the service plan and waiting list data as a current need. The outcome/objective shall also be added to the Individual Support Plan. The Employment Program Specialist reviews the

referral packet and determines if the member will go directly to Center-Based Employment or if the packet will be sent to Rehabilitation Services Administration/Vocational Rehabilitation Program.

Members/families that are referred to the Vocational Rehabilitation Program receive an orientation and complete an application. The Vocational Rehabilitation Program then determines eligibility for services. If eligible, services will be provided by the Vocational Rehabilitation Program.

The Support Coordinator should then take the VRI service off the wait list and open it as an indirect service.

If ineligible, the Vocational Rehabilitation Program will close the case and the member will be and referred back to the Division. At this point, the member with their Individual Support Plan team, including the District Employment Program Specialist, will reconvene to determine how best to meet the member's need for an employment related service. The VRI code should be removed from the wait list.

602.4.5 Service Provision Guidelines (Employment Supports and Services)

Transition from the Vocational Rehabilitation Program to the Division of Developmental Disabilities

The Vocational Rehabilitation Program counselor notifies the Support Coordinator of upcoming transitions. The Support Coordinator then notifies the Employment Program Specialist of anticipated transitions. The Support Coordinator contacts the member/family and offers a list of Qualified Vendors. The member/family selects a Qualified Vendor. The Qualified Vendor is then notified and given an opportunity to accept or decline service provision.

When a Qualified Vendor is identified, a transition meeting with the member/family, the Vocational Rehabilitation counselor, the Support Coordinator, and Qualified Vendor is held to review the employment placement. This transition meeting is also used to review progress and services still needed by the member/family. The needed supports for the member's success and the date of transfer are also determined at the Vocational Rehabilitation transition meeting.

Authorization for Employment Supports and Services

The authorization process for Employment Supports and Services starts with the Support Coordinator adding the appropriate code to the Service Plan. The Support Coordinator then submits the authorization request to the District designee. The District designee generates authorization for services.

The Qualified Vendor is informed in writing of service authorization and may only provide the services that have been authorized by the Division. Any change in services will require a new written authorization.

Service Changes (Employment Supports and Services)

Any change in Employment Supports and Service, including changes from one employment service to another, or from an employment service to a different day service, requires Planning Team agreement and notification of the District Employment Program Specialist. Progressive moves within Employment Supports and Services require a Request for Employment Supports and Services Packet to be completed.

Tracking and Reporting (Employment Supports and Services)

The Qualified Vendor is required to submit individualized monthly progress reports on Division forms to the Support Coordinator. The Support Coordinator ensures that Qualified Vendors submit required reports and will address reported issues.

The Support Coordinator will contact the District Employment Program Specialists if concerns cannot be resolved. The Qualified Vendor will submit a report on Division forms every six months to the Employment Program Specialist.

Monitoring and Technical Support (Employment Supports and Services)

At a minimum, the District Employment Program Specialist will perform an annual on-site Quality Assurance Review of all Qualified Vendors who provide Employment Supports and Services. The Employment Program Specialist will also review the Qualified Vendors' "six month" reports, and provide on-site visits and technical support as needed.

602.5 Habilitation

Description (Habilitation)

This service provides learning opportunities designed to help a member develop skills and independence.

Barring exclusions noted in this section, based on member and family priorities Habilitation may be provided to:

A. Increase or maintain independence and socialization skills.

B. Increase or maintain safety and community skills.

C. Increase or maintain the member’s health and safety.

D. Provide training in:

1. Essential activities required to meet personal and physical needs.

2. Alternative and/or adaptive communication skills.

3. Self-help/living skills.

E. Develop the member's support system to reduce the need for paid services.

F. Help family members learn how to teach the member a new skill.

G. When this service is authorized in conjunction with a Habilitation Behavioral Masters/Bachelors program, the Habilitation Hourly provider will follow the plan developed by the Habilitation Behavioral Masters/Bachelors provider.

Considerations (Habilitation)

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

A. Existing community support systems have been exhausted and no other service is more appropriate.

B. The member's documented needs cannot be met by the member's support system, employment program or a day program.

C. Habilitation can support therapy home program strategies.

Settings (Habilitation)

Habilitation Services may be provided:

A. Hourly or daily in the member's own home.

B. Hourly in the home the member shares with the family.

C. Daily in a group home.

D. Hourly in a Child Protective Services licensed foster home.

E. Daily in a developmental home.

F. Hourly in other community settings (e.g. a Habilitation provider can assist a child in participating in a private pay day care/after school program).

Exclusions (Habilitation)

Exclusions to the authorization of Habilitation Services include, but are not limited to:

A. Habilitation shall not substitute for Respite or day care.

B. Habilitation shall not be used in place of regular educational programs as provided under Public Law 108-446 IDEA Part B.

C. Habilitation shall not substitute for funded or private pay day programs.

D. Habilitation shall not be used when another service is more appropriate.

E. Hourly Habilitation shall not be authorized when Daily Habilitation is authorized.

F. Habilitation shall not be provided in private or public schools during school hours or in transit to schools.

G. Habilitation shall not be provided in a provider's residence unless the residence is also the home of the member receiving the service.

H. Hourly Habilitation shall not be provided in a Qualified Vendor owned or leased service site.

I. Hourly habilitation shall not be offered in vendor supported Child Development Foster Homes or Adult Developmental Homes unless the following are met:

1. There is a specific issue, problem or concern that is believed to be temporary or short term.
2. The Planning Document must outline specific, time limited goals/outcomes regarding the service to be provided.
3. Monthly progress reports validate continuing the service.

602.6 Home Health Aide

602.6.1 Service Description and Goals (Home Health Aide)

This service provides intermittent medically necessary health maintenance, continued treatment or monitoring of a health condition and supportive care for activities of daily living at the member's place of residence. A Home Health Aide serves as an assistant to the primary caregiver, under the supervision of a licensed, registered nurse following a plan of care based upon the member's medical condition as prescribed by the Primary Care Provider (PCP) and authorized by Health Care Services (HCS).

The goal of this service is to increase or maintain self-sufficiency of eligible members.

602.6.2 Service Settings (Home Health Aide)

Home Health Aide services are provided in the member's home, but are not provided in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) Nursing Facility (NF) or hospital.

602.6.3 Service Requirements (Home Health Aide)

A. This service shall be supervised by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse. The agency supervisor shall conduct home visits at least every 60 days.

B. The service shall follow a plan of care developed by the supervisor, member and provider, in accordance with the PCP, which includes monitoring vital signs; changing dressings and/or bandages; care and prevention of bedsores; assistance with catheter (not to include insertion); assistance with bowel, bladder and/or ostomy program; assistance with self-medication; nail and skin care; assistance with personal hygiene; assistance with eating; assistance with ambulation, range of motion and exercise activities; assistance with special appliances and/or prosthetic devices; and transfers to and from wheelchair.

C. The service may include teaching the primary caregiver how to perform the home health tasks contained in the plan of care.

D. The service must be prescribed by a licensed physician as part of a written plan of care that shall be reviewed and recertified by the physician at least every 60 days.

602.6.4 Target Population (Home Health Aide)

This service is indicated for members who have a health condition that requires intermittent assistance, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan.

602.6.5 Exclusions (Home Health Aide)

Exclusions to the provision of Home Health Aide services include, but are not limited to:

A. Home Health Aide service shall not be used in place of another, more appropriate service such as Personal Care or Habilitation.

B. Home Health Aides shall not provide skilled nursing services.

602.6.6 Service Provision Guidelines (Home Health Aide)

In addition to requiring a physician's order, a nursing assessment must be completed prior to Home Health Aide service being provided. This assessment may be done by the District Utilization Review Nurse or by a nurse from HCS. Approval for this service must come from HCS.

602.6.7 Provider Types and Requirements (Home Health Aide)

Designated District staff will ensure all contractual requirements related to Home Health Aide providers are met before services can be provided. Additionally, all providers of Long Term Care Services must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.6.8 Service Evaluation (Home Health Aide)

A. The physician will review the plan of care at least every 60 days and prescribe continuation of the service.

B. The agency nurse supervisor will review the plan of care at least every 60 days for appropriateness.

C. The provider will submit progress notes on the plan of care on a monthly basis to the Support Coordinator.

602.6.9 Service Closure (Home Health Aide)

Service closure should occur in the following situations:

A. Based on the plan of care, it is determined by the physician that the service is no longer needed.

B. The member/responsible person decline the service.

C. The member moves out of state.

D. The member requires other, more appropriate services (e.g., home nursing or personal care).

E. The member/responsible person has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

602.7 Home Nursing

602.7.1 Service Description and Goals (Home Nursing)

This service provides nursing intervention in the member's place of residence. Services may include patient care, coordination, facilitation and education.

Home health nursing includes intermittent and continuous nursing services as described in Chapter 1200 of the AHCCCS Policy Manual (Policy 1240) www.azahcccs.gov/.

Intermittent Nursing Services

Intermittent nursing services must be ordered by a physician and provided by a registered nurse or a licensed practical nurse. Skilled nursing assessments are required for monitoring purposes. The service provider must also submit written monthly progress reports to the member's primary care provider or attending physician for intermittent nursing services.

Continuous Nursing Services

Continuous nursing services/home health private duty nursing must be ordered by a physician and provided by a registered nurse or a licensed practical nurse in accordance with 42 CFR 440.80 (www.gpo.gov). Continuous nursing services may be provided for members who are ALTCS eligible and reside in their own home. Continuous nursing services are provided as an alternative to hospitalization or institutionalization when care cannot be safely managed within the scope and standards of intermittent nursing care and when determined to be cost-effective.

The goals of this service are to:

A. Increase or maintain self-sufficiency of eligible members.

B. Improve or maintain the physical well-being of eligible members.

602.7.2 Service Settings (Home Nursing)

The service shall not be provided in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), Nursing Facility (NF) or hospital.

602.7.3 Service Requirements (Home Nursing)

Before Home Nursing can be authorized, the following criteria must be met:

A. All members receiving this service shall have a nursing assessment done by a Division Nurse to determine skilled intervention, which includes:

1. A review of the current medical files including all pertinent health-related information, to identify potential health needs of the member related to the Division nursing assessment.

2. Assessment of the health status of the member by a review of the current medical data, communication with the member, team members and families and assessment of the member in relation to physical, developmental and behavioral dimensions.

3. When home nursing services are identified by the Division Nurse, a referral is submitted to the Division contracted home

health nursing providers. The home nursing service provider must obtain an order from the primary care provider to perform duties related to home nursing care.

B. A licensed primary care provider must prescribe the services as a part of a written "plan of care". This "plan of care" must be reviewed and recertified by the primary care provider at least every 60 days.

C. The service shall follow a written nursing plan of care developed by the Division contracted Home Health provider, in conjunction with the Division's Support Coordinator, the member/responsible person and the Division Nurse which includes:

1. Specific services to be provided.

2. The person who will provide the specific service.

3. Anticipated frequency and duration of each specific service.

4. Expected outcome of services.

5. Coordination of these services with other services being received or needed by the member.

6. Input of the member/responsible person.

7. Assisting the member in increasing independence.

The nursing plan of care shall be included in and reviewed by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team).

602.7.4 Target Population (Home Nursing)

Support Coordinators will identify members who potentially need nursing through the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan process (Planning Process) and will submit a referral to the Division Nurse. The Division Nurse upon referral from the Support Coordinator will complete a nursing assessment and if the need is justified, a referral will be made to a contracted Division nursing agency. The contracted Division nursing agency will be responsible to obtain a written order from the primary care provider to perform the duties of home nursing care. The allocation of skilled nursing care hours is determined by the Division Nurse; based on the nursing needs identified on the Division nursing assessment.

602.7.5 Exclusions (Home Nursing)

Exclusions to the provision of Home Nursing include:

A. Nurses may not provide service under physician's orders and prescribed medical procedures that have been changed by someone other than the physician.

B. Nurses may not be paid to provide other services, such as personal care during the time they are providing home nursing.

C. Home nursing shall not be used for day care.

D. Nurses shall not provide direct supervision of non-licensed persons engaged in service provision.

602.7.6 Service Provision Guidelines (Home Nursing)

In addition to requiring a physician's order, a nursing assessment must be completed prior to Home Nursing being provided. The Division Nurse will complete this assessment.

602.7.7 Provider Types and Requirements (Home Nursing)

Designated District staff will ensure all contractual requirements related to Home Nursing are met before services can be provided. Additionally, all providers of Long Term Care Services must be certified by the Division and registered with the AHCCCS prior to service initiation.

602.7.8 Service Evaluation (Home Nursing)

A. Written assessment shall be completed quarterly by the Division Nurse, maintained on file and a copy sent to the Support Coordinator.

B. The Division contracted home health provider shall complete a nursing care plan and submit a copy to the Division Nurse and the Support Coordinator.

C. Each nursing plan of care from the Division contracted home health nursing provider shall be updated at least every 60 days. Any revisions to the plan shall be sent to the Division Nurse and the Support Coordinator.

D. All physician orders shall be maintained and implementation documented in each member's file.

E. Any contact made on behalf of the member shall be documented.

602.7.9 Service Closure (Home Nursing)

Service closure should occur when assessments by the Division Nurse, in conjunction with the Support Coordinator, indicate no further need for skilled nursing.

A. The Division Nurse is to inform the primary care provider that skilled nursing service is no longer required.

B. The Division Nurse is to inform the Division contracted home health provider that skilled nursing service is no longer required. The Division contracted home health provider is to obtain a discharge order from the primary care provider.

In addition to the member's home, nursing services may also be provided in group homes, developmental homes, Level I and Level II behavioral health facilities or day treatment and training programs as appropriate.

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

602.8 Hospice

602.8.1 Service Description and Goals (Hospice)

Hospice services significantly impacts members/families served by the Division who are in the process of making end of life decisions. The Division is determined to ensure that the existence of a member's disability bears no influence on end of life decisions and is committed to protect the best interest of people with developmental disabilities.

The Division is also determined to ensure that the decision to provide life-sustaining treatment to members is determined by using the same standards of judgment used to assess the same decisions regarding persons without developmental disabilities.

The Division is opposed to decision-making to hasten death due to the perception that people with developmental disabilities have a "low quality of life" and believes that the lives of all people are valuable. As a result, the Division is committed to helping members obtain the best care possible. The Division also believes that treatment should be conducted in accordance with the member's wishes or what is understood to best represent the member's best interests.

Situations may arise where the burden of medical treatment outweighs the benefit to the member. The Division is aware of situations where members, families and health care providers weigh the benefits of care when there is no hope for improved health and the prolonging of life no longer benefits the "patient."

The Division discourages the removal of life sustaining devices. If the member, surrogate, and medical experts determine that life sustaining devices are not in the

member's best interest, they may determine other options. A member's disability should not be a determining factor when considering whether or not to remove life sustaining devices.

First, treatment that provides no discomfort and alleviates pain may be continued. Next, treatment that needlessly prolongs suffering may be eliminated while maintaining those devices that allow for comfort and rest. Finally, all life sustaining devices may be removed in an effort to allow the progression of natural events to take place, unless the cessation of certain devices would cause pain and discomfort.

Division staff confronted with end of life situations should do the following:

A. Share the Division's perspective on the lives of members.

B. Emphasize that the member's disabilities should not influence medical decisions.

C. Encourage cooperation, and open communication to determine the member's best interest with family members, surrogate decision makers, and health care providers.

D. When a member has an advanced directive, durable power of attorney, health care directive power of attorney, or any such legal document, the Division respects the member's lawful wishes as specified in the legal document.

E. If there is no such legal document providing guidance in end of life situations the following need to be considered:

1. The member's ability to participate in the activities and functions that provide pleasure and value to their lives.

2. The member's health condition.

3. The benefit of treatment.

4. Treatment options.

5. The members best interest.

Hospice services are provided to Arizona Long Term Care System (ALTCS) members who meet medical criteria/requirements and are not based on a person's disability. Hospice services provide palliative and support care for terminally ill members and their family or caregivers. Hospice services provide health care and emotional support for terminally ill members and their families/caregivers during the final stages of life.

602.9 Homemaker (Housekeeping)

602.9.1 Service Description and Goals (Homemaker)

This service provides assistance in the performance of activities related to routine household maintenance at a member's residence. The goal of this service is to increase or maintain a safe, sanitary and/or healthy environment for eligible members.

602.9.2 Service Settings (Homemaker)

This service would occur in the member's own home or family's home. It would occur outside only when unsafe/unsanitary conditions exist and would occur in the community when purchasing supplies or medicines.

602.9.3 Service Requirements (Homemaker)

Before Homemaker can be authorized, the following requirements must be met:

A. Safe and sanitary living conditions shall be maintained only for the member's personal space or common areas of the home the member shares/uses.

B. Tasks may include:

1. Dusting.

2. Cleaning floors.

3. Cleaning bathrooms.

4. Cleaning windows (if necessary to attain safe or sanitary living conditions).

5. Cleaning oven and refrigerator (if necessary to prepare food safely).

6. Cleaning kitchen.

7. Washing dishes.

8. Changing linens and making beds.

9. Routine maintenance of household appliances.

C. Washing, drying and folding the member's laundry (ironing only if the member's clothes cannot be worn otherwise).

D. Shopping for and storing household supplies and medicines.

E. Unusual circumstances may require the following tasks be performed:

1. Tasks performed to attain safe living conditions:

i. Heavy cleaning such as washing walls or ceilings.

ii. Yard work such as cleaning the yard and hauling away debris.

2. Assist the member in obtaining and/or caring for basic material needs for water heating and food by:

i. Hauling water for household use.

ii. Gathering and hauling firewood for household heating or cooking including sawing logs and chopping wood into usable sizes.

iii. Caring for livestock used for consumption including feeding, watering and milking.

3. Provide or insure nutritional maintenance for the member by planning, shopping, storing and cooking foods for nutritious meals.

602.9.4 Target Population (Homemaker)

Members who are eligible for or are receiving assistance through the Supplemental Payment Program (SPP) will not receive Housekeeping. Members who are not eligible for Long Term Care Services should be referred to the SPP. Needs are assessed by the Support Coordinator based upon what is normally expected to be provided by a member and/or his/her caregiver. It is important to remember that housekeeping services are based on "assessed need" and not on a person's or the family's stated desires regarding specific services.

Consideration should be made to age appropriate expectations of the member and his/her entire family (what can reasonably be expected of each member based on his/her age). The team should consider the natural supports are available and not supplant them. In addition to the guidelines found in section 602, there may be a need for the SPP if any of the following are factors:

A. A member is living with his/her family and has intense medical, physical or behavioral needs and the family members are unable to care for the member and maintain a safe and sanitary environment.

B. A member is living with his/her family and the family members have their own medical/physical needs that prevent the family members

from maintaining a safe and sanitary environment (documentation of the medical/physical needs may be required).

C. A member is living independently and has medical/physical needs that preclude him/her from maintaining/attaining a safe and sanitary environment.

D. A member is living independently and has demonstrated that he/she cannot maintain a safe and sanitary environment. Habilitation should be considered before using Housekeeping so the member's abilities may be maximized.

E. The family is experiencing a crisis that prevents them from maintaining a safe and sanitary environment. The situation would be documented in the member's progress notes and the service delivery would be of a time-limited nature.

602.9.5 Exclusions (Homemaker)

The following exclusions apply to the provision of Homemaker:

A. Homemaker is to be performed only for the member's areas of the home or common areas of the home used by the member, i.e., parents' or sibling's bedrooms or bathrooms would not be cleaned. Other examples of inappropriate use of Homemaker services include:

1. Cleaning up after parties.

2. Cleaning up several days of accumulated dishes.

3. Preparing meals for the whole family.

4. Routine lawn care.

B. Homemaker shall not be provided to members residing in group homes, vendor supported developmental homes, skilled nursing facilities, non-state operated Intermediate Care Facilities for Persons with an Intellectual Disability or Level I or Level II behavioral health facilities.

602.9.6 Service Provision Guidelines (Homemaker)

Typical utilization of Homemaker would be 2 - 4 hours per week. Additionally:

A. The member or family is expected to provide all necessary supplies.

B. This service shall not be provided when the member is hospitalized or otherwise receiving institutional services. The service may only be

provided at the end of hospitalization to allow the member to return to a safe and sanitary environment.

C. Members residing in group homes, foster homes or adult developmental homes shall not receive this service.

Utilization of Homemaker will be in accordance with the Service Authorization Matrix.

602.9.7 Provider Types and Requirements (Homemaker)

Designated District staff will ensure all contractual requirements related to Homemaker providers are met before services can be provided. Additionally, all providers of Long Term Care Services must be certified by the Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.9.8 Service Evaluation (Homemaker)

The Individual Support Plan/Individualized Family Service Plan/Person Centered Plan review (Plan Review) shall document appropriateness of this service based upon the Support Coordinator's observation and input from the member, family and provider.

602.9.9 Service Closure (Homemaker)

This service is no longer appropriate when:

A. The member’s medical, physical or behavioral needs have decreased.

B. The physical/medical needs of the family members have decreased.

C. The family is no longer experiencing crisis.

D. The member no longer resides at home, has moved out of state or when the member is no longer eligible for Long Term Care Services (refer to the Supplemental Payment Program).

E. The member moves to a residential or institutional setting.

F. The family has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in of this policy manual.

602.9.10 Other Homemaker Services

A. The amount of Homemaker provided shall be determined based on the home requirements for a safe and sanitary environment. If more than one eligible member resides in the home, payment will not be made twice for cleaning common areas of the home.

B. If the family is receiving supplemental payments for other members in the home, the Support Coordinator shall determine if the Supplemental Payment Program (SPP) is meeting the family's needs.

602.10 Intermediate Care Facilities for Persons with an Intellectual Disability

602.10.1 Service Description and Goals (Intermediate Care Facility for Individuals with an Intellectual Disability)

This service provides health and habilitative services to members with developmental disabilities.

The goal of this service is to provide an environment in which the programmatic and habilitative needs of eligible persons are met through an active treatment process.

A continuous active treatment program includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the member to function with as much self-determination as possible; and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent members who are able to function with little supervision or in the absence of a continuous active treatment program.

602.10.2 Service Settings (Intermediate Care Facility for Individuals with an Intellectual Disability)

Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) shall only include the Arizona training program facilities, a State owned and operated service center, State owned or operated residential settings or existing licensed facilities operated by the State or under contract with the Department on or before July 1, 1988.

A.R.S. § 36-2939(B)(1) azleg.gov/ArizonaRevisedStatutes.asp

602.10.3 Service/Provider Requirements (Intermediate Care Facility for Individuals with an Intellectual Disability)

A. The ICF/IID shall be reviewed annually by the Department of Health Services and certified by Arizona Health Care Cost Containment System (AHCCCS) or pursuing certification.

B. The ICF/IID shall be licensed, certified and monitored in accordance with A.R.S. § 36-591(G). azleg.gov/ArizonaRevisedStatutes.asp

C. The ICF/IID shall comply with the conditions set forth in Chapter 42 of the Code of Federal Regulations. www.gpoaccess.gov/cfr/

D. The ICF/IID shall comply with A.A.C. R6-6-901 through R6-6-910 Managing Inappropriate Behaviors. azsos.gov/public_services/rules.htm

E. A Cost Effectiveness Study (CES) shall be completed prior to admission or discharge from an ICF/IID.

602.10.4 Target Population (Intermediate Care Facility for Individuals with an Intellectual Disability)

A. Health Care Services requires review and revision of the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) prior to any permanent/temporary admission to a private ICF/IID. The Support Coordinator shall forward the Planning Documents to Health Care Services (HCS). The written authorization of the Assistant Director shall be required prior to placement.

B. Prior to considering a permanent/temporary placement in a state operated ICF/IID, the Division Support Coordinator shall exhaust all other placement options (including private ICF/IID and written approval by the Assistant Director is required).

602.10.5 Exclusions (Intermediate Care Facility for Individuals with an Intellectual Disability)

ICF/IID placements shall not be made when appropriate, cost effective services are available in the community.

Therapeutic leave shall not exceed 9 days and bed hold days shall not exceed 12 days per calendar year.

602.10.6 Service Provision Guidelines (Intermediate Care Facility for Individuals with an Intellectual Disability)

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602.10.7 Service Evaluation (Intermediate Care Facility for Individuals with an Intellectual Disability)

The provider shall comply with the conditions set forth in Chapter 42 of the Code of Federal Regulations (www.gpo.gov). In addition to certification reviews by

Department of Health Services, the Division's Quality Assurance Unit will do "Continued Stay Reviews" and "Active Treatment Reviews".

602.10.8 Service Closure (Intermediate Care Facility for Individuals with an Intellectual Disability)

The member shall be discharged from an ICF/IID as appropriate, in accordance with the following:

A. A new Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Document) and Cost Effectiveness Study shall be completed prior to the anticipated discharge, at least 10 days in advance, except in those cases where the discharge is of short duration, i.e., 5 days or less.

B. A discharge plan shall be developed including the participation of the member and all Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) members and the discharge plan shall take precedence. The member/responsible person, the Primary Care Provider (PCP), the attending Physician and the Division's Medical Director shall resolve disagreements when there are differences between the Planning Documents and the discharge plan. The Division's Medical Director shall have the final authority as delegated by the Assistant Director.

C. The member's PCP shall be given the opportunity to participate in the Individual Support Plan/Individualized Family Services Plan/ Person Centered Plan meeting (Planning Meeting) and to review the respective documents.

D. The District Utilization Review Nurse shall participate in the Planning Meetings. The nurse shall ensure the discharge planning process has been completed and shall certify concurrence with the plan by signing these documents.

E. The District Program Manager/District Program Administrator (DPM/DPA) shall certify concurrence by signing the discharge plan.

F. The discharge plan, with the required signatures, shall be forwarded to the Division's Health Care Services (HCS) and Medical Director for final review and certification.

G. The completed discharge package shall be returned to the DPM/DPA for implementation of the plan.

The entire process above shall be completed before the discharge is made.

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

602.11 Nursing Facility

602.11.1 Service Description and Goals (Nursing Facility)

This service provides skilled nursing care, residential care, and supervision to persons who need nursing services on a 24-hour basis, but who do not require hospital care under the daily direction of a physician.

The goal of this service is to provide an environment that meets and enhances the medical, physical and emotional needs of members residing in nursing facilities.

602.11.2 Service Settings (Nursing Facility)

Nursing facilities must be Medicare and Medicaid certified unless not available in the community. For the purposes of reimbursement by Arizona Long Term Care System (ALTCS) funding, the facility must be Medicaid certified.

602.11.3 Service/Provider Requirements (Nursing Facility)

Designated District staff must ensure the following are met before service is initiated:

A. The NF must be licensed and certified by the appropriate Arizona state agencies and comply with all applicable federal and state laws relating to professional conditions, standards and requirements for NF(s).

B. The NF must also comply with all health, safety and physical plant requirements established by federal and state laws.

C. The Contractor must be registered with Arizona Health Care Cost Containment System (AHCCCS) to provide this service for that portion of the facility subject to Medicaid reimbursement.

602.11.4 Target Population (Nursing Facility)

Members in need of skilled nursing care on a 24-hour basis may be considered appropriate for this service. Prior to admission, the member must be screened in accordance with federal law (see Pre-Admission Screening/Annual Resident Review (PASRR) section of this policy manual) and reviewed for appropriateness of placement whenever a significant change in the physical or mental status of the member occurs.

602.11.5 Exclusions (Nursing Facility)

Long Term Care Services may be provided only in Medicare and Medicaid certified NF(s). State funded services do not need to be provided in Medicare or Medicaid certified facilities. No payments may be made for inappropriate placements pursuant to Chapter 42 Code of Federal Regulations 456.1 (www.gpo.gov, see also Section PASRR section of this policy manual).

The AHCCCS will advise the Division when a NF is placed on termination status due to noncompliance with Medicaid/Medicare participation requirements. No new admissions can be made to a NF on termination status.

Members currently residing in or on leave from a NF placed on termination status may remain in or return to the facility, if each member's Primary Care Provider (PCP) agrees with the District Utilization Review Nurse's assessment that the NF can continue to meet the needs of the member.

If the PCP or District Utilization Review Nurse does not feel the NF can meet the member's needs, the member must be offered a choice of available alternatives to include home and community based services.

Therapeutic leave shall not exceed 9 days and bed hold days shall not exceed 12 days per calendar year.

602.11.6 Service Provision Guidelines (Nursing Facility)

In addition to requiring a physician's order, a nursing assessment must be completed prior to NF Services being provided. This assessment will be done through the PASRR process.

602.11.7 Service Evaluation (Nursing Facility)

Members residing in NF(s) must be reviewed when there is a significant change in the physical or mental condition of the member (PASRR section of this policy manual) in addition to the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process (Planning Process). Physicians shall certify the need for nursing facility placement in accordance with Chapter 42 Code of Federal Regulations. www.gpo.gov

602.11.8 Service Closure (Nursing Facility)

Nursing Facility services will be terminated when there is no longer a need for 24-hour skilled nursing care, as determined by the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Document/Meeting) and the physician following the PASRR recommendations. The discharge shall occur as follows:

A. A new Planning Document shall be completed prior to the anticipated discharge at least 10 days in advance except in those cases where discharge is of short duration, i.e., 5 days or less.

B. The discharge plan shall be the document through which the discharge of the member is managed. All members of the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) shall be involved in the discharge planning process and the discharge plan shall take precedence. The member or responsible person, the Primary Care Provider (PCP), attending Physician and the Division's Medical Director shall resolve disagreements regarding discharge planning.

C. The member's PCP shall be given the opportunity to participate in the Planning Meetings and to review the respective Planning Documents.

D. The District Utilization Review Nurse shall participate in the Planning Meetings. The District Utilization Review Nurse must also ensure discharge planning has been completed by signing these respective documents.

E. The Division's District Program Manager/District Program Administrator (DPM/DPA) signature is also required on the discharge plan.

F. The discharge plan with the required signatures shall be forwarded to the Division's Medical Services Manager.

G. Health Care Services (HCS) and the Division's Medical Director shall conduct the final review.

H. The complete discharge package shall be returned to the DPM/DPA for implementation of the plan

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

602.12 Respite

602.12.1 Service Description and Goals (Respite)

This service provides short-term care to relieve caregivers. Members who are cared for by Respite providers must be eligible for supports and services through the Division. Respite providers may be required to be available on a 24-hour basis. Respite services are intended to temporarily relieve unpaid caregivers. Respite services are not intended as a permanent solution for placement or care. The number of hours authorized for Respite services must be used for Respite services and cannot be transferred to another service.

602.12.2 Service Settings (Respite)

Respite may be provided in the following settings:

A. The member's home.

B. A Medicare/Medicaid certified Nursing Facility.

C. A group home foster home or adult developmental home certified by the Division.

D. A certified Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID).

E. A provider's home that complies with the requirements of the Department of Health Services or the Division.

602.12.3 Service Requirements (Respite)

Before Respite can be authorized, the following requirements must be met:

A. Prior to initiating service, the provider shall meet with the primary caregiver to obtain necessary information regarding the member.

B. The provider shall:

1. Supervise the member and meet their social, emotional and physical needs.

2. Ensure the member receives all prescribed medications in the ordered dose and time.

3. Administer First Aid and give appropriate attention to injury or illness.

4. Supply food to meet daily nutritional needs including any prescribed therapeutic diets.

5. Furnish transportation as needed to day programs and appointments.

6. Carry out any programs as requested by the Planning Team.

7. Report any unusual incidents to the Division in accordance with policies and procedures.

8. Ensure appropriate consideration of member needs, compatibility and safety when caring for unrelated members.

602.12.4 Target Population (Respite)

Respite, as a medically related social service is appropriate based upon family needs, as written in the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents). Respite services are also appropriate based on the following factors:

A. The primary caregiver is unable to obtain Respite and other supports from his/her immediate/extended family or from other community resources.

B. The primary caregiver needs time to recover from abnormally stressful situations in order to resume his/her responsibilities.

C. The member with a developmental disability presents intense behavioral challenges or needs a high degree of medical care.

D. The primary caregiver is experiencing an emergency that temporarily prevents performance of normal responsibilities.

E. The primary caregiver requires more frequent or extended relief from care responsibilities due to advanced age or disability.

F. The family is experiencing unusual stressors such as care for more than one person who has a developmental disability.

G. Respite services can only be provided for children ages 0 to 3 related to required training for the primary caregiver. This training requirement must be documented in the Individualized Family Services Plan (IFSP). https://www.azdes.gov/azeip/

602.12.5 Exclusions (Respite)

Exclusions to the provision of Respite services may include the following:

A. Respite shall not substitute for routine transportation, day care or another specific service.

B. Respite shall not substitute for a residential placement.

C. Respite providers shall not serve more than three people at one time.

D. Foster care (child developmental homes) and adult developmental home providers shall not give services to more members than would exceed their Division license.

E. Foster care (child developmental homes) and adult developmental home Respite providers shall not give services to children and adults simultaneously. This is only allowed if stated on the license.

Additionally, the provider shall not offer services to adults if the license is for children and vice versa.

F. Respite is not available for members living in group homes or an ICF/IID.

G. Assisted Living Centers, non-state operated ICF/IID, skilled nursing facilities; Level I or Level II behavioral health facilities and members living independently are not approved for Respite.

602.12.6 Service Provision Guidelines (Respite)

A. The federal government and the Arizona Heath Care Cost Containment System (AHCCCS) set the upper limit of 600 hours per year regarding Respite services for members who are eligible for Long Term Care. Respite Service hours are determined on a yearly basis by the initial Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents.

B. Members who are eligible for Respite services funded by the state are subject to the availability of these funds. The continuation of Respite services is determined on a yearly basis through the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents. Respite services are intended to allow unpaid primary care givers a break and, as such, the assessment for Respite hours will need to be reconciled with the amount of time an unpaid primary caregiver usually provides support.

C. All hours of Respite utilized by the member/family will be tracked and reported. Respite hours for members who are eligible for Long Term Care Service will be reported to AHCCCS.

D. For Respite billing information see Department of Economic Security, Division of Developmental Disabilities Rate Book located on the Division's website at https://www.azdes.gov/uploadedFiles/Developmental_Disabilities/ddd_ratebook.pdf.

E. A negotiated rate will be applied for families who have more than one person eligible for Respite. This negotiated rate will be reported by the provider, with the total actual hours of service given to each member on the Uniform Billing Document. This method of rate setting will be applied when these members receive Respite at the same time. The hours used will be deducted by the Division from the authorized level of Respite for each person.

F. Families receiving Respite for a member eligible for services from the Division who wish other non-eligible members to receive care will be responsible for the costs of serving the non-eligible member. The Division will only pay for services delivered to members authorized to receive such service and will pay the provider at a multiple client rate.

602.12.7 Provider Types and Requirements (Respite)

Designated District staff will ensure all contractual requirements related to Respite providers are met before service can be provided. Additionally, all providers of Long Term Care Services must be certified by the Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.12.8 Service Evaluation (Respite)

The Support Coordinator must continually assess the quality of the services provided to members with developmental disabilities in accordance with the mission statement. Additionally:

A. The provider shall submit attendance reports summarizing the members served and the number of hours of service to the designated District representative. All incidents shall be reported to the Division within the required timelines.

B. The Support Coordinator and the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) shall determine the on-going appropriateness of the service based upon the input from the providers and the member's caregiver(s).

602.12.9 Service Closure (Respite)

A. Respite shall terminate when the member begins to live independently or in a Group Home, Vendor Supported Developmental Homes or, Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) or Nursing Facility (NF).

B. Respite shall terminate when the family no longer desires the service.

C. Respite for members who are eligible for services through the Arizona Long Term Care System (ALTCS) shall terminate when the maximum amount allowed has been used and there are no State funds available.

A Notice of Intended Action must be sent in accordance with the processes defined in of this policy manual.

602.13 Room and Board

602.13.1 Service Description and Goals (Room and Board)

This service provides for a safe and healthy living environment on a 24-hour basis that meets the physical and emotional needs of a member.

602.13.2 Service Settings (Room and Board)

Room and board may be provided in any state operated or contracted community residential setting.

602.13.3 Service Requirements (Room and Board)

Before Room and Board can be authorized, the following requirements must be met:

A. Living arrangements for members served must be identified

B. Nutritional maintenance for members served must be ensured and provided.

602.13.4 Target Population (Room and Board)

All members receiving services in a residential setting may also receive room and board.

602.13.5 Exclusions (Room and Board)

Exclusions to the provision of Room and Board include Home and Community Based Services. Other room and board services excluded are those funded by Arizona Long Term Care System (ALTCS). All other fund sources shall be exhausted prior to funding by the Division.

602.13.6 Service Provision Guidelines (Room and Board)

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602.13.7 Provider Types and Requirements (Room and Board)

Designated District staff will ensure all contractual requirements are met before Room and Board is provided.

602.13.8 Service Evaluation (Room and Board)

The provider shall maintain an on-site file that documents appropriate inspections and licenses necessary to operate the home.

602.13.9 Service Closure (Room and Board)

This service shall be terminated when a member moves from a State operated or contracted residential setting.

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

602.14 Therapies – Occupational, Physical and Speech

Description (Occupational, Physical and Speech)

Therapy services provide medically necessary activities to develop, improve or restore functions/skills. Therapy services require a prescription, are provided or supervised by a licensed therapist, and are not intended to be long term services.

Occupational therapy may address the use of the body for daily activities such as, dressing, sensory and oral motor development, movement, and eating.

Physical therapy may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting, and other movements.

Speech therapy may address receptive and expressive language, articulation, fluency, eating and swallowing. Barring exclusions noted in this section, Therapy includes the following:

A. Evaluation of skills.

B. Development of home programs and consultative oversight with the member, family and other providers.

C. Assisting members to acquire knowledge and skills, increase or maintain independence, promote health and safety.

D. Modeling/teaching/coaching parents and/or caregivers specific techniques and approaches to everyday activities, within a member's routine, in meeting their priorities and outcomes.

E. Collaboration with all team members/professionals involved in the member's life.

Responsible Person's Participation (Occupational, Physical and Speech)

To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, parents/family or other caregivers (paid/unpaid) are required to:

A. Be present and actively participate in all therapy sessions.

B. Carry out the home program.

Considerations (Occupational, Physical and Speech)

The following will be considered when approving this service:

A. Developmental/functional skills.

B. Medical conditions.

C. Member's network of support (e.g., family/caregivers, friends, providers).

D. Age.

E. Therapies provided by the school.

Settings (Occupational, Physical and Speech)

Therapy shall be provided in settings that support outcomes developed by the team. This includes:

A. The member's home.

B. Community settings.

C. Division funded settings such as day programs and residential settings for the purpose of training staff.

D. Daycare.

E. A clinic/office setting.

Exclusions (Occupational, Physical and Speech)

Exclusions to the authorization of Therapy services may include but are not limited to the following:

A. Rehabilitative therapy (acute therapy) due to an accident, illness, medical procedure, or surgery. Rehabilitative therapy includes restoring former functions or skills due to an accident or surgery.

   Funding for rehabilitative therapy shall be sought from:
   1. Private/third party insurance,
   2. Children's Rehabilitative Services (CRS),
   3. American Indian Health Services (AIHS),
   4. Comprehensive Medical and Dental Plan (CMDP),
   5. Arizona Health Care Cost Containment System (AHCCCS), or
   6. DD/ALTCS Acute Health Care Plan.

B. Physical therapy is provided by the DD/ALTCS Acute Health Care Plan for members 21 years and older and will not exceed 15 visits for developmental/restorative, maintenance and rehabilitative therapy for the benefit year.

C. Therapy for educational purposes.

602.15 Respiratory Therapy

602.15.1 Service Description and Goals (Respiratory Therapy)

This service provides treatment to restore, maintain or improve respiration.

The goals of this service are to:

A. Provide treatment to restore, maintain or improve respiratory functions.

B. Improve the functional capabilities and physical well-being of the member.

602.15.2 Service Settings (Respiratory Therapy)

The Division does not authorize rates for respiratory therapy as a stand-alone service that is separate from other services provided in a particular setting. Although, respiratory therapy may be provided to the member in any setting, it is part of the established rate for Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Nursing Facilities (NF).

602.15.3 Service Requirements (Respiratory Therapy)

Before Respiratory Therapy can be authorized, the following requirements must be met:

A. The service must be prescribed by a qualified, licensed physician as part of a written plan of care that must include the frequency, duration and scope of the therapy.

B. The provider must be licensed by the Arizona Board of Respiratory Care Examiners and be a graduate of an accredited respiratory care education program. This program must be accredited/approved by the American Medical Association's Committee on Allied Health Education and in collaboration with the Joint Review Committee for Respiratory Therapy Education.

C. The provider shall be designated for members who are eligible for Long Term Care services and registered with the Arizona Health Care Cost Containment System (AHCCCS).

D. Tasks may include:

1. Conducting an assessment and/or review previous assessments, including the need for special equipment.

2. Developing treatment plans after discussing assessments with the Primary Care Provider, the District Nurse and the Planning Team.

3. Implementing respiratory therapy treatment as indicated by the assessment(s) and the member's treatment plan.

4. Monitoring and reassessing the member's needs on a regular basis.

5. Providing written reports to the Division staff, as requested.

6. Attending Planning Meetings (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meetings) if requested by the member and Division staff.

7. Developing and teaching therapy objectives and/or techniques to be implemented by the member, caregivers and/or other appropriate individuals.

8. Consulting with members, families, Support Coordinators, medical supply representatives and other professional and paraprofessional staff on the features and design of special equipment.

9. Giving instruction on the use and care of special equipment to the member and care providers.

602.15.4 Target Population (Respiratory Therapy)

This service is indicated for members who have a health condition that require respiratory therapy, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents).

602.15.5 Exclusions (Respiratory Therapy)

Respiratory Therapy is prohibited without Physicians orders and prescriptions for certain medical procedures. This requirement does not apply to private or state-operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID).

602.15.6 Service Provision Guidelines (Respiratory Therapy)

Respiratory Therapy shall not exceed eight (8) fifteen (15) minute sessions per day.

602.15.7 Provider Types and Requirements (Respiratory Therapy)

Designated District staff will ensure all contractual requirements related to Respiratory Therapy providers are met before the service is approved. Additionally, all providers of Long Term Care Services must be registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.15.8 Service Evaluation (Respiratory Therapy)

A. The Primary Care Provider (PCP) will review the plan of care at least every 60 days and prescribe continuation of service.

B. If provided through a Medicare certified home health agency, the supervisor will review the plan of care at least every 60 days.

C. The provider will submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

602.15.9 Service Closure (Respiratory Therapy)

Service closure should occur in the following situations:

A. The physician determines that the service is no longer needed as documented on the "Plan of Care.

B. The member/responsible person declines the service.

C. The member moves out of State.

D. The member requires other services, such as home nursing.

E. The member/responsible person has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in this policy manual.

The Division supports and encourages continuity of care among all therapy resources such as hospitals, outpatient rehabilitation clinics and schools. The Division contracted therapists shall collaborate with other service providers and agencies involved with the member.

602.15.10 Habilitative Therapy

Habilitative therapy directs the member's participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is

described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and is based on needs identified in the these respective documents. Habilitative therapy is available through the Division and some Health Plans through Early and Periodic Screening, Diagnosis and Treatment Medicaid program. Habilitative therapy also provides for direct treatment by a licensed therapist.

Habilitative therapy may utilize direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

602.16 Transportation (Non-Emergency)

602.16.1 Service Description and Goals (Transportation)

Non-emergency transportation shall be provided for members who are unable to provide their own transportation for medically necessary services. This service provides non-emergency ground transportation as prior approved by the Division if the member's natural supports cannot provide such transportation.

The goal of this service is to increase or maintain self-sufficiency, mobility and/or community access of eligible members.

602.16.2 Service Requirements (Transportation)

Transportation can be provided for members who are eligible for Long Term Care to and from other covered services.

602.16.3 Target Population (Transportation)

A. The need for transportation is assessed and documented by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process.

B. Transportation is appropriate when member/family resources, supports or community resources are not adequate or available.

602.16.4 Exclusions (Transportation)

Exclusions for transportation services include:

A. Providers shall not transport more members than can travel safely.

B. Transportation for members who are eligible for Long Term Care Services to medical appointments should be coordinated through the health plan.

C. Members residing in Vendor Supported Child Developmental Homes and Vendor Supported Adult Developmental Foster Homes, Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Group Homes shall not receive additional transportation.

602.16.5 Service Provision Guidelines (Transportation)

A. Members who are eligible for Long Term Care services may use forty-six (46) trips per month to covered day programs.

B. Members who are eligible for Long Term Care services may use eight (8) trips per month to other covered services.

602.16.6 Provider Types and Requirements (Transportation)

Designated District staff will ensure all contractual requirements related to Transportation providers are met before services can be given. Additionally, all providers of Long Term Care services must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.16.7 Service Evaluation (Transportation)

This service shall be reviewed at all Planning Team meetings.

602.16.8 Service Closure (Transportation)

A. This service shall be terminated when the member no longer requires transportation.

B. This service shall be terminated if other resources become available.

603 Acute Care Service Delivery

The Division, as a program contractor for Arizona Long Term Care System (ALTCS), is responsible to provide acute care services to members who are eligible for Long Term Care services.

603.1 Contracted Health Plans

Members who are eligible for Long Term Care services are required to join one of the Division's contracted health plans, where available. The exception is Native Americans who may choose to enroll in American Indian Health Plan.

The contracted health plan subcontracts with physicians, hospitals, therapists, dentists, laboratories, pharmacies, medical equipment suppliers and other providers to deliver acute care services to enrolled members.

All services must be delivered or ordered by the Primary Care Provider (PCP), determined to be medically necessary by the health plan and delivered by a contracted provider. The PCP is the member's designated physician who coordinates all aspects of the member's medical care. Members who are eligible for Long Term Care services that fail to follow these procedures and receive services that are not approved/provided by a health plan provider are responsible to pay for these services.

The members who are eligible for Long Term Care services may choose to use their own doctor if the physician is an Arizona Health Care Cost Containment System (AHCCCS) registered provider and is contracted with the health plan. In these instances, the health plan's or the Division's approval is still needed for services covered by Arizona Long Term Care System.

If the member who is long term care eligible is enrolled in a health plan and has a Primary Care Provider (PCP), but also chooses to use another physician who may not be registered with AHCCCS, services provided or ordered by this physician are not covered by the AHCCCS. Services by a physician who is not registered with the AHCCCS can be covered by the health plan if approved by the PCP and the health plan. If approval is not received from the PCP and the health plan, the member will be required to pay for the services personally or through private insurance.

Children's Rehabilitative Services (CRS)

Members eligible for ALTCS may also be eligible for Children's Rehabilitative Services (CRS). Members eligible for the Division and CRS will receive CRS specialty services and behavioral health services through United Healthcare Community Plan or its successor. These members will continue to receive acute care services through their Division acute health plan.

Comprehensive Medical and Dental Program

The Comprehensive Medical and Dental Program (CMDP) is a health care program for Arizona's children who are wards of the court and placed out of home. Eligibility is based on State law. Child Protective Service (CPS) coordinates services related to CMDP.

Member Acute Care Card

Members who are determined eligible for Long Term Care services will receive a membership card from the Division or the Division's contracted acute health plan, and will be enrolled in a contracted acute health plan by the Division or receive services on a fee-for-service basis through the Division.

Health Plan Responsibilities

Each contracted acute health plan is required to send members a health plan member handbook. The handbook explains the services that are covered, how to access these services, and what to do when emergency services are needed. It outlines the member's responsibility to follow procedures. All services must be provided or approved by the primary care provider

An ALTCS member who fails to follow procedures outlined in the member handbook and receives services that are not approved or provided by a health plan contracted physician may be responsible to pay for those services.

The Division may delegate some or all of its responsibility to a health plan for the following non-inclusive health care responsibilities. These services are rendered on behalf of members who are ALTCS members and enrolled with the health plan:

A. Prior authorization of services and procedures as specified by the health plan.

B. Claims processing according to policies and procedures defined by the health plan.

C. Concurrent review, including certification and denial of inpatient hospital stay days, according to health plan procedures.

D. Investigation and resolution of complaints and grievances according to policy and procedure specified by both AHCCCS and the health plan.

E. Provider relations and member services activities.

F. Financial monitoring and reporting as mandated under AHCCCS rules.

G. All other quality assurance and utilization management activities as defined in the Title 42 of the Code of Federal Regulations (http://www.gpoaccess.gov/cfr/), AHCCCS Rules (azahcccs.gov/Regulations/), and the health plan's quality assurance/utilization review procedures.

All such services/responsibilities must be in compliance with AHCCCS/ALTCS Rules and Regulations (azahcccs.gov/Regulations/).

604 Acute Care Services

604.1 Inpatient Hospital (Acute Care Services)

Inpatient hospital services are medically necessary services delivered or directed by a Primary Care Provider (PCP), a specialist physician, practitioner or dentist. These

services are ordinarily furnished in an acute care hospital, except for services in public or correctional facilities, or Behavioral Health settings.

The following is a list of the minimum inpatient hospital services that are available to members who are eligible for Long Term Care services.

Routine services including:

A. Hospital room and board.

B. Medical supplies, appliances and equipment ordinarily furnished to hospital inpatients that are billed as part of routine services and are included in the daily room and board charge.

C. Intensive care and coronary care.

D. Nursing care.

E. Dietary management.

F. Up to seventy-two (72) hours of acute behavioral health services. The health plans will provide acute behavioral health services in accordance with AHCCCS Rules for members not enrolled with a Regional Behavioral Health Authority (RBHA). The RBHA provides acute behavioral health services for their enrollees.

Supplementary services including:

A. Maternity services including labor, delivery, recovery rooms, and birthing centers.

B. Surgery, including operating and recovery rooms.

C. Clinical laboratory.

D. Radiological and medical imaging.

E. Anesthesiology.

F. Rehabilitation including speech, occupational and physical therapies.

G. Pharmaceutical services.

H. Respiratory therapy.

I. Receiving blood and blood products.

J. Receiving central supply items including appliances and equipment that are not ordinarily furnished to all patients and that are customarily reimbursed as additional services.

K. Nursery and related services.

L. Chemotherapy services.

M. Dialysis in accordance with AHCCCShttp://www.azsos.gov/PUBLIC_SERVICES/Table_of_Contents.htm

N. Total parenteral nutrition services.

O. Podiatry services, as covered in the AHCCCS policy 2.14.0, (azahcccs.gov/Regulations) performed by a podiatrist, licensed pursuant to A.R.S. Title 32, Chapter 7 (http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp), and ordered by a Primary Care Provider (PCP).

604.2 Outpatient Services (Acute Care Services)

Outpatient health care services are those services provided outside of the acute care inpatient hospital setting. These include both palliative (designed to alleviate pain and discomfort) and therapeutic (designed to improve the condition) services directed or administered by a PCP. The services may be preventive, diagnostic or rehabilitative in nature. The following minimum outpatient health care services may be provided to members who are eligible for services through the Arizona Long Term Care System (ALTCS):

A. Ambulatory surgery and anesthesiology not specifically excluded by the AHCCCS Rules. azahcccs.gov/Regulations

B. Physician services including patient education and routine physical examinations as designated by the AHCCCS policy and procedures. azahcccs.gov/Regulations

C. Pharmaceutical services and prescribed drugs included in the Division's Formulary. Also including vaccines to prevent Hepatitis B, medically necessary psychotropic for the control of seizures and spasticity and non-prescription medication when cost-effective and prescribed by a physician.

D. Clinical laboratory services, including routine screening for Hepatitis B.

E. Radiological and medical imaging.

F. Services of nurse practitioners and physician assistants when referred by or under the supervision of a PCP.

G. Nursing services provided in an outpatient health care facility.

H. Covered medical supplies and equipment authorized by the member's PCP.

I. The use of twenty-four (24) hour emergency, examination or treatment rooms when required for the administration of physician services. Emergency room and medical emergency service will be provided 24 hours a day, 7 days a week.

J. Podiatry services, as covered in the AHCCCS Policy and Procedure Manual 2.14.0 (azahcccs.gov/Regulations), performed by a podiatrist, licensed pursuant to A.R.S. Title 32, Chapter 7, (azleg.gov/ArizonaRevisedStatutes.gov) and ordered by a Primary Care Provider (PCP).

K. Home physician visits as medically necessary.

L. Dialysis in accordance with the AHCCCS Rules. azahcccs.gov/Regulations

M. Specialty care physician services shall be considered covered services only when requested by a PCP.

N. Rehabilitation services including occupational, physical and speech therapies prescribed by a PCP and in accordance with the AHCCCS Rules. azahcccs.gov/Regulations

O. Respiratory therapy.

P. Total parenteral nutrition services.

Q. Enteral nutritional supplements when prescribed as medically necessary by a PCP.

R. Annual physical examinations for adults and children, periodic health examinations, health assessments, physical evaluations, diagnostic procedures or health protection packages, that include groups of tasks or procedures designed to:

1. Determine risk of disease.

2. Provide early detection of disease.

3. Detect the presence of injury or disease at any stage.

4. Establish a treatment plan for injury or disease.

5. Evaluate the results or progress of a treatment plan for the disease.

6. Establish the presence and characteristics of a physical disability that may be the result of disease or injury.

S. Outpatient behavioral health services, including psychotropic medications, in accordance with the AHCCCS Rules.

T. Medically necessary home nursing in lieu of hospitalization when ordered by the Primary Care Provider (PCP).

U. Hospice services.

604.3 Clinical Laboratory, Radiological and Medical Imaging Services (Acute Care Services)

Clinical laboratory procedures (including routine screening for Hepatitis B), radiological and medical imaging services prescribed by a Primary Care Provider (PCP) or by another physician, practitioner or dentist upon referral by a PCP and which are ordinarily administered in hospitals, clinics, physicians' offices or other health care facilities by licensed health care providers shall qualify as covered services if medically necessary.

Clinical laboratory, radiological and medical imaging service providers shall satisfy all applicable State license and certification requirements, be registered with the Arizona Health Care Cost Containment System (AHCCCS), and shall perform only those services specific to their license and certification.

604.4 Pharmacy (Acute Care Services)

Pharmaceutical services include medically necessary drugs prescribed by Primary Care Provider (PCP), other physicians, practitioners or dentists upon referral by a PCP Psychotropic drugs for the control of seizures and spasticity shall be covered, as well as vaccines used to prevent Hepatitis B. At a minimum, items listed in the Division’s Formulary shall be included as covered benefits for members who are eligible for Long Term Care services.

Psychotropic drugs for behavioral health symptoms shall be covered according to the AHCCCS Rules.

Prescriptions shall be dispensed with a 30-day supply of medication, if authorized by the prescriber.

Pharmaceutical services shall be available to members during customary business hours and shall be located within reasonable travel distance.

604.5 Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services)

Medical supplies, durable medical equipment orthotic and prosthetic devices provided to members who are eligible for Long Term Care services qualify as covered services if prescribed by a, specialist physician, practitioner or dentist upon referral by a PCP.

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment.

Experience has demonstrated that the cost-effective provision of Durable Medical Equipment includes the involvement of a physical therapist in ordering and fitting customized equipment.

Medical supplies and Durable Medical Equipment include:

A. Surgical dressings, splints, casts and other disposable items covered by Medicare (Title XVIII).

B. Rental or purchase of Durable Medical Equipment, including, customized equipment.

C. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

604.6 Adaptive Aids (Acute Care Services)

Certain medically necessary adaptive aids qualify as a covered service if prescribed by a specialist physician, practitioner or dentist upon referral by a Primary Care Provider (PCP).

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment. It is important to remember that this service is based on "assessed need" and not a person's or the family's stated desires regarding specific services.

Covered adaptive aids are limited to:

A. Traction equipment.

B. Feeding aids (including trays for wheelchairs).

C. Helmets.

D. Standers, prone and upright.

E. Toileting aids.

F. Wedges (positioning).

G. Transfer aids.

H. Augmentative communication devices.

I. Medically necessary car seats.

J. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

604.7 Dental Services

Dental services for members who are Long Term Care eligible aged 0 to 21 years are covered when provided by a licensed dentist per A.R.S. §32-1207 and A.R.S. §32-1231 for maintenance of dental health, prevention and treatment of disease and injury, in an appropriate dental facility.

Informed consent must be obtained from the member or responsible person(s) prior to any treatment including those noted in #1 below. Written consent must be obtained prior to major outpatient treatments. The dentist must obtain the consent.

The following services are covered:

A. Preventive dental services - performed annually unless otherwise requested by Primary Care Provider (PCP) include:

1. Oral examinations.

2. Radiological and medical imaging services.

3. Oral prophylaxis - includes scaling and polishing and application of topical fluoride and sealants, if appropriate.

4. Dental treatment plan.

5. Dental education.

B. Restorative treatment, including:

1. Restorative and primary amalgams.

2. Composite restoration (anterior teeth).

3. Sedative base.

4. Permanent teeth.

C. Orthodontia when medically necessary and prior authorized by the health plan or the Division's Medical Director.

D. Endodontic services (pulp capping, pulpotomy and recalcification).

E. Crown and bridge services.

F. Prosthetics.

G. Oral surgery includes extraction of symptomatic teeth and post-operative visits.

H. Orthognathic surgery.

I. Medically necessary dentures.

604.8 Rehabilitative Therapy

Rehabilitation is the process of re-establishing former functions or skills. This includes physical, occupational and speech therapies. This service may occur after a trauma has decreased the functioning of a member. Rehabilitative therapies are not designed to build a skill or functioning level that had not been previously present in the member.

604.9 Maternal and Child Health

There are several programs that support maternal and child health. These include Early and Periodic Screening, Diagnosis and Treatment (EPSDT), family planning, pregnant women's program and mental health. These programs are described below:

A. EPSDT is the component of the Medicaid Program established in 1969 as the federally mandated screening and treatment program for children birth to age 21.

The goal of EPSDT is to provide health care through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems identified by well child checks and screens.

An EPSDT must include:

1. A comprehensive health and developmental history (including both physical and behavioral health assessment).

2. As of January 1, 2006, the Prenatal Evaluation of Development Status (PEDS) developmental screening tool should be utilized for developmental screening by the primary care provider for EPSDT-age members who were admitted to the neonatal intensive care unit. The PEDS screening should also be conducted at each EPSDT well child visit.

3. A comprehensive unclothed physical examination.

4. Appropriate immunizations according to age and health history.

5. Laboratory tests (including blood lead levels).

6. Health education.

7. Appropriate dental screening.

8. Appropriate vision screening and hearing testing.

9. Diagnostic services whenever a screening examination indicates the need to conduct a more in depth evaluation of the child's health status and to provide diagnostic studies.

As the Medicaid authority in Arizona, AHCCCS administers the Early and Periodic Screening Diagnosis and Treatment program. Children who are eligible for Medicaid are eligible for EPSDT services. Children who are eligible for Long Term Care services are also Medicaid eligible. Additionally, these children are eligible for EPSDT services.

Arizona Health Care Cost Containment System (AHCCCS), contracts with health plans to provide all EPSDT services to all AHCCCS eligible children in Arizona.

The Division also contracts with the health plans to provide EPSDT services to children who are Long Term Care eligible. The Division provides those services identified as habilitative to children who are Long Term Care eligible. The health plans are under contract to provide rehabilitative services to children who are Long Term Care eligible.

Medicaid funds are available to pay for medically necessary services identified for a child with a disability in his/her Individualized Educational Plan, Individual Family Service Plan, Individual Support Plan or Person Centered Plan.

All services authorized in the federal Medicaid law must be provided to children who are eligible for EPSDT. These services include:

1. Screening.

2. Evaluation.

3. Clinic services.

4. Rehabilitative services.

5. Physical therapist services.

6. Occupational therapist services.

7. Speech pathology and audiology services.

8. Psychological treatment.

9. Social services.

10. Inpatient psychiatric facility services.

11. Outpatient behavioral health services.

An authorization for services can only be denied for lack of a finding of medical necessity. It cannot be denied for any other reason for children who are eligible for the AHCCCS program and Division services.

EPSDT means those procedures or professional services which are required to maintain, correct or ameliorate a physical, emotional or developmental problem which is discovered through screening, examination or evaluation or which is found to have worsened since a previous screening.

For more detailed information on EPSDT, refer to the AHCCCS Medical Policy Manual at Section 430. www.azhcccs.gov/Regulations

B. Family Planning - Medicaid allows for the provision of Family Planning Services. The goal of Family Planning Services is to enable a member to make choices in both the timing and occurrence of pregnancies. This service is available through the member's Primary Care Provider (PCP) and is part of the services offered by the health plans. Division health plans are required to educate their Providers on the full scope of available family planning services and how members may obtain them.

C. Pregnant Women's Program - One step toward accomplishing this goal is to ensure that pregnant women receive early and continuous prenatal care from a qualified obstetrical provider. Prenatal care is arranged through the member's PCP.

D. Behavioral Health Programs – members who are eligible for Long Term Care services needing behavioral health services may be referred by their Division Support Coordinator, the Division Behavioral Health Coordinator, and the physician or by themselves to a Regional Behavioral Health Authority (RBHA) for evaluation and service planning. Covered services must comply with the AHCCCS behavioral health policies and procedures. Inpatient and outpatient services are covered as well as appropriate prescription drugs.

604.10 Podiatry

Routine foot care can be covered when the performance of such services by other than professional members would be hazardous to members who have concurrent diseases such as diabetes mellitus or thrombophlebitis.

604.11 Organ Transplant

Organ transplant services and procurement shall be in accordance with AHCCCS Rules (www.azhcccs.gov/Regulations). Organ transplant services also require written prior authorization from the Division and AHCCCS.

604.12 Extended Care Coverage

Health plans for members who are eligible for Long Term Care are financially responsible for a maximum of 90 days. This financial responsibility includes nursing facility care, and room and board, after -hospital discharge. Nursing Facility (NF) care must be in lieu of hospitalization. If the member's place of residence prior to hospitalization was a NF the health plan is not financially responsible for placement. Members requiring nursing facility placement beyond 90 days are the financial responsibility of the Division. Preadmission Screening/Annual Resident Review (PASRR) Level II reviews must occur for each member whose expected stay in the NF will exceed 90 days

Division staff will work expeditiously with the health plan's discharge planners to place the member in the least restrictive environment as required by state law.

604.13 Home Health Services

Home health services through the health plan are those services provided by a Home Health Agency that coordinate in-home intermittent services. These services include, home health aide services, medical supplies, equipment and appliances. The service must be ordered by the Primary Care Provider (PCP) in lieu of hospitalization and referred by the health plan to a Medicare Certified Home Health Agency.

604.14 Emergency Ambulance and Medically Necessary Transportation

Emergency transportation via ground or air ambulance and transportation to access acute care services is a covered benefit. Transportation services are limited to occasions when no other means of travel is appropriate or available or in emergency situations. The nearest provider or medical facility capable of meeting the member's medical needs shall be utilized.

604.15 Travel Expenses (Meals, Lodging, Transportation and Attendant Services)

Expenses incurred for meals, lodging and transportation for a member while en route to or from a health care service site out of the member's service area or county of residence are covered services.

The PCP must write an order for attendant care services. The Attendant Care Provider's meals, lodging and transportation expenses are covered. On occasion the Attendant Care Provider may accompany a member out of the service area or county of residence. These attendant care providers may also be a family member who lives in the same household as the member. Under these circumstances services are covered if a written order from the PCP is issued. The Attendant Care Provider's salary is covered only if the attendant does not live in the same household as the member. Expense receipts must be sent to the health plan or Health Care Services for fee-for-service counties. Receipts for meals and lodging must not exceed the State per diem. Transportation will be reimbursed at 9 cents per mile.

The following exclusions and limitations apply:

A. Family household members, friends and neighbors may be reimbursed for providing transportation services only if the services are ordered in writing by the PCP and free transportation or public transportation is not available.

B. A charitable organization providing transportation services at no cost. A charitable organization may not charge or seek reimbursement for the provision of such services to Long Term Care.

C. Payment for meals, lodging and transportation of a member and an Attendant Care Provider are funded when a member requires covered service that are not available in the health plan's service area. This criterion also applies to the salary for an attendant.

604.16 Out-Of-Area Coverage

Out of Area Service

Arizona Long Term Care System (ALTCS) eligible members who need emergency medical services when out of the service area may go to an emergency room.

Emergency medical services are those services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate attention could be expected to result in:

A. Placing the patient's health in serious jeopardy

B. Serious impairment of bodily functions

C. Serious dysfunction of any bodily organ or part

Providers must notify the health plan within 12 hours of emergency service provision. Non-emergency services out of the member's service area will not be covered.

Services cannot be provided to a member outside the United States.

Covered services are required to be provided within the service area of the health plan except as follows:

A. Referral of a member by a PCP, out of the health plan's service area for medical specialty-care (including Children's Rehabilitative Services).

B. Services for members traveling or temporarily residing out of their health plan's service area are restricted to emergency care services, unless otherwise authorized by the health plan.

C. A covered service is not available within the health plan's service area.

D. A net savings results from transportation to another area for services.

E. The health plan provides written authorization for services based on cost or scope of service considerations.

604.17 Incontinence Briefs

A. The Division's acute care contracted health plans shall provide incontinence briefs, including pull-ups and incontinence pads, for members who are between 3 and 21 years of age and who are eligible for the ALTCS program. Briefs may be provided in order to prevent skin breakdown and to enable participation in social, community, therapeutic and education activities. These supplies will be provided under the following circumstances:

1. The member is incontinent due to a documented disability that caused incontinence of bowel and/or bladder.

2. The PCP or attending physician has issued a prescription ordering the incontinence briefs.

3. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder.

4. The member obtains incontinence briefs from providers in the Contractor's network.

5. Apply appropriate prior authorization requirements. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit.

   Prior authorization is permitted to ascertain that:

   i. The member is over age 3 and under age 21;

   ii. The member has a disability that causes incontinence of bladder and/or bowel;

   iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard brief supplied by the contractor; and,

   iv. The prescription is for 240 briefs of fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

B. The Division's acute care contracted health plans shall provide incontinence briefs, including pull-ups, for members 21 years of age and older to treat a medical condition or to prevent skin breakdown when all the following are met:

1. The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder.

2. The PCP or attending physician has issued a prescription ordering the incontinence briefs;

3. Incontinence briefs do not exceed 180 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 180 briefs per month;

4. The member obtains incontinence briefs from vendors within the Contractor's network; and,

5. Prior authorization has been obtained if required by the Administration, Contractor, or Contractor's designee, as appropriate. Contractors shall not require a new prior authorization to be issued more frequently than every 12 months.

C. The Division shall provide incontinence briefs for members who are between 3 and 21 years of age who are:

1. Group home residents that do not qualify for Medicaid (ALTCS or targeted).

2. Group home residents that qualify for Medicaid (ALTCS) and have been denied incontinence briefs by the assigned health plan and other medical insurance coverage (e.g., Medicare), if applicable.

D. Authorized services must be for at least a 12 month period of time.

E. Contractors may require a new prior authorization to be issued no more frequently than every 12 months.

F. Incontinence briefs will not be covered by Children's Rehabilitative Services (CRS).

G. Payments for the use of incontinence briefs for the convenience of caregivers will not be authorized.

H. If a member is eligible for Fee For Service coverage, the Health Care Services Unit will prior authorize using the same criteria outlined above. Health Care Services Prior Authorization can be contacted by calling 602-771-8080.

I. Any exceptions to this policy section must have the approval of the Assistant Director.

604.18 Supplemental Nutritional Feeding

This policy provides criteria for the evaluation and authorization of supplemental nutritional feedings (oral-enteral formula) for members eligible for Long Term Care covered services through the Division. It also addresses the issue of medical necessity, assessment and authorization of non-specialty formula.

604.18.1 Criteria for Medical Review and Prior Authorization (Supplemental Nutritional Feeding)

A. The Primary Care Provider (PCP) or physician specialist must make the request. A Physician has requested nutritional feeding by a physician assistant or nurse practitioner. In order to make this request, the physician assistant or nurse practitioner must be under the medical management of the PCP. A request made by a physician specialist must be routed through the PCP for continuity of care. Requests shall be routed through appropriate channels of the health plan or to the Prior Authorization Nurse in Health Care Services for fee-for-service. Items to be submitted for medical review include:

1. All current diagnoses.

2. Current or recent (within 6 months) laboratory data such as chemistry panel, iron binding studies, etc.

3. Growth chart with current height and weight history. A family history of unusual growth patterns, i.e., emaciated, short stature, etc. should be included, as appropriate.

4. The history of ambulation or physical activities.

5. The history of gastrointestinal health.

6. A current nutritional assessment and a summary of client/caregiver education done by a registered dietitian.

7. A 3, 5 or 7 day diary of dietary intake, as appropriate.

8. The speech or occupational therapy evaluation related to any oral-motor, dentition, chewing or swallowing problems, as applicable.

9. Current medications including an analysis of possible medication/nutrient interaction affecting absorption.

10. All alternative approaches to the use of oral-enteral formulas attempted and the outcomes.

11. The specific goals of oral-enteral formulas with a follow-up and weaning plan over a specific time frame.

B. Monitoring of the client's progress on the oral-enteral formula is the responsibility of the PCP or designee and shall include:

1. Nutritional assessment follow-up at the following intervals:

   i. Members on oral-enteral formulas less than five (5) years shall receive an assessment every three (3) months.

ii. Members on oral-enteral formulas five (5) to fourteen (14) years shall receive an assessment every six (6) months.

iii. Members on oral-enteral formulas over fourteen (14) years shall receive an assessment annually.

2. Alternatives to commercially prepared formulas should be considered whenever possible including blenderized foods for members beyond the normal formula age (3 years) if possible.

C. Members who are eligible for the Women, Infant and Children (WIC) program should be encouraged to use that program first. The Division's fee-for-service or the subcontracted health plan will make up the difference between the WIC Program, the authorized amount and the PCP requested amount.

604.18.2 Member Management (Supplemental Nutritional Feeding)

Members should be followed by:

A. The health plan.

B. The agency providing the formula.

C. The Division's Health Care Services for Fee For Service.

604.18.3 Authorization Process (Supplemental Nutritional Feeding)

A. Definitions

1. Enteral - "within or by way of the intestine." For the purposes of this policy, enteral will mean the delivery of nutritional feedings to the intestinal tract by way of a feeding tube such as nasogastric, oral-gastric, gastrostomy, jejunostomy or a gastrostomy button.

2. Oral - any nutritional formula or food that is ingested by mouth.

B. Authorization guidelines

1. Authorization for oral-enteral formula or supplemental nutritional feedings will be granted if the following criteria are met. The health plan Medical Director or the Division Medical Director must also deem oral-enteral formula or supplemental feedings as medically necessary for Fee for Service. The criteria for authorization are as follows:

i. The member is at or below the 10th percentile on the appropriate growth chart for their age, gender or disability, e.g., Down syndrome, for greater than three months.

ii. The member has reached a plateau in growth and/or nutritional status for greater than six months (pre-pubescent).

iii. The member has demonstrated a decline in growth status within the last three months.

iv. The member is able to obtain/eat no more than 50% of his/her nutritional requirement from normal food sources.

v. Absorption problems as evidenced by emesis, diarrhea, dehydration, weight loss and intolerance to milk or formula products have been ruled out.

vi. Unsuccessful trials of alternatives such as blenderized foods have been documented over a reasonable period of time with the involvement of a nutritionist.

2. The Prior Authorization Nurse will submit all documentation for evaluation by the health plan Medical Director or the Division Medical Director regarding fee-for-service.

3. Re-authorization for supplemental nutritional feeding formula will be determined by the age of the member (based on the nutritional evaluation for age set forth in Section 604.19.1.b).

604.19 Service Provision Guidelines (Supplemental Nutritional Feeding)

Covered services may be limited in amount, duration and scope. Certain services are specifically excluded from coverage. These limitations and exclusions are documented in AHCCCS Rules and apply to all covered acute care services. Exclusions include:

A. Services rendered by non-registered providers.

B. Services or items furnished solely for cosmetic purposes.

C. Services for which required prior authorization was not obtained from the health plan.

D. Services or items furnished gratuitously or for which charges are usually not made.

E. Services rendered in a public institution for treatment of tuberculosis or for the treatment of mental disorders for members between ages 21 and 65.

F. Hearing aids for members age 21 and older.

G. Treatment and services determined to be experimental or provided primarily for the purpose of research.

H. Services of a private or special duty nurse except when medically necessary and with prior authorization by the health plan.

I. Sex change operations.

J. Reversal of voluntarily induced infertility;

K. Care not deemed medically necessary by Health Care Services, the PCP or not included in the AHCCCS Rules. www.azahcccs.gov/Regulations

L. Medical services provided to a member who is an inmate of a public institution as defined in Chapter 42 Code of Federal Regulations 435.1009 (www.gpoaccess.gov/cfr/) or who is in the custody of a State mental health facility.

M. Artificial, mechanical, or xenograft heart transplant.

N. Organ transplants except those specifically covered by A.R.S. §36-2907(A) (E) (F) azleg.gov/ArizonaRevisedStatutes.asp as authorized by the health plan.

O. Abortions not medically necessary.

P. Hysterectomies which are not medically necessary.

Q. Abortion counseling.

R. Optional family planning clinic services as defined by federal law.

Services cannot be denied based on moral or religious grounds.

605 Medical Marijuana

Medical marijuana is not a covered medical or pharmacy benefit. Office visits or any other services that are for the purpose of determining if a member would benefit from medical marijuana are also not covered. Under no circumstance shall any employee of the Department and any owner, director, principal, agent, employee,

subcontractor, volunteer, and staff of the Division's service providers administer or store medical marijuana for Division members.

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700 ASSESSMENTS

701 Overview

This chapter addresses the Division of Developmental Disabilities (Division) requirements for specific evaluation and assessment. It describes formal and informal methods of assessment, including the use of the Pre-Admission Screening and Resident Review (PASRR).

702 Assessment Requirements for Members Placed in Residential Settings

Members residing in settings operated or financially supported by the Division must receive certain assessments. The residential staff is responsible for obtaining documentation of the following within 30 days of admission:

A. Physical examination.

B. Complete medical history.

C. Immunization record.

D. Tuberculosis screening.

E. Hepatitis B screening.

F. Type of developmental disability.

G. Medication history.

H. History of allergies.

I. Dental history.

J. Seizure history.

K. Developmental history.

L. Family medical history.

In addition, the Planning Team (Individual Support Plan/Individualized Family Services Plan team) must ensure that additional evaluations and assessments are identified and obtained.

A.A.C. R6-6-806(B)
http://www.azsos.gov/public_services/Title_06/6-06.pdf

703 Preadmission Screening and Resident Review (PASRR)

Federal nursing home reform legislation enacted through the 1987 Omnibus Reconciliation Act (OBRA) established the Pre-Admission Screening and Resident Review (PASRR) Program. The PASRR regulations mandate that all members entering a Title XIX (Medicaid) certified nursing facility be screened for a cognitive/intellectual disability or a related diagnosis and/or mental illness to avoid inappropriate placement. In addition, the OBRA specifies that placement for members with a cognitive/intellectual disability or mental illness are made based on their needs for nursing facility services and for specialized services.

(42 CFR 483.100 through 483.138)

http://www.gpo.gov/fdsys

State Medicaid agencies are required to develop a two-stage identification and evaluation process, which accomplishes the following:

PASRR Level I – Identification of potential cognitive/intellectual disability or mental illness - Determines whether the member has any diagnosis or other presenting evidence that suggests the potential of a cognitive/intellectual disability or mental illness.

PASRR Level II (Determination) – Determines whether the member does indeed have a cognitive/intellectual disability or mental illness. If the member has been determined to have a cognitive/intellectual disability or mental illness, this stage of the evaluation process determines whether the member requires the level of services provided by a nursing facility and/or specialized services.

703.1 Service Description

The procedures described in this section will apply to all members seeking admission of a 30-day or longer stay in a Title XIX or Medicaid certified nursing facility.

703.2 State Agreement Requirements

Referrals for a PASRR Level II determination of cognitive/intellectual disability are handled by the Arizona Department of Economic Security through the Division. Intergovernmental agreements between the AHCCCS Administration and the Division have been established to develop and maintain the Level II process to determine whether each member referred by primary care providers, nursing facilities or the AHCCCS/ALTCS Administration (PAS Assessors) requires the level of services provided by a nursing facility and/or specialized services for a cognitive/intellectual disability.

703.3 Cognitive/intellectual disability

Developmental disability is defined as a chronic disability which is attributable to a cognitive/intellectual disability, cerebral palsy, epilepsy, autism and any related condition. The disability results in the impairment of general intellectual functioning or adaptive behavior and requires medical treatment or services. The impairment must be manifested before the age of 22. The impairment must be likely to continue indefinitely and result in substantial functional limitations in major life activities. When determined by a medical professional the range of intellectual functioning (mild, moderate, severe, and profound) will be documented on the PASRR Level II Evaluation.

703.4 Specialized Services (as pertaining to cognitive/intellectual disability)

The services specified by the cognitive/intellectual disability authority which, when combined with services provided by the nursing facility or other service providers, result in treatment which includes aggressive, consistent implementation of a program of specialized and/or generic services and related services that are directed toward the following:

A. The acquisition of behaviors necessary for the member to function with as much self-determination and independence as possible; and

B. The prevention or deceleration of regression or loss of current optimal functional status.

If there are indications of a cognitive/intellectual disability or a related diagnosis, the completed PASRR Level I and all supporting documentation should be forwarded to the Division. Supporting documentation may include the Minimum Data Set (MDS), health and progress notes, assessments, or other documentation by a medical professional that suggests the presence of a cognitive/intellectual disability. Specialized services include aggressive, consistent implementation of a program of specialized and/or generic services and related services that are directed toward the acquisition of behaviors necessary for the member to function with as much self-determination and independence as possible, and the prevention or declaration of regression or loss of current optimal functional status.

The PASRR Level I is reviewed by the PASRR Coordinator who then determines if a Level II is necessary. If so:

A. The PASRR Coordinator will contact the facility and speak to the referring member to confirm the current placement and that the medical files for the resident will be reviewed.

B. The Minimum Data Set (MDS) in the member's file will also be reviewed for information concerning the member's functioning level and medical problems. The information gathered from the MDS and the member's resident's medical files will assist in completing the Level II.PASRR Level II determinations must be completed within an average of 7 to 9 working days of receipt of referral.

42 CFR 483.112 (c)
http://www.gpo.gov/fdsys/

IF THE MEMBER IS AWAITING DISCHARGE FROM A HOSPITAL, THE LEVEL II WILL BE COMPLETED AS SOON AS POSSIBLE, AND IF NECESSARY BEFORE THE FEDERALLY MANDATED 7 to 9 WORKING DAYS TIMEFRAME.

703.5 PASRR Determination

The PASRR Level II evaluation instrument and necessary procedures developed by the Division gather pertinent information needed to determine and recommend appropriate levels of care and services and when applicable in the least restrictive environment that could continue to provide the needed medical treatment. The criteria used in making a decision about appropriate placement will not be affected by the availability of placement alternatives.

703.6 Evaluation Requirements

PASRR reviews will be adapted to the member's cultural background, language, ethnic origin and means of communication. Current and relevant assessment information obtained prior to the initiation of the PASRR process may be used. Findings must be accurate and correspond to the members' current functional level and must be descriptive.

The Division may convey the determinations verbally to the referring agency and the member and then confirm them in writing in accordance with 42 CFR 483.112 (c-2).

http://www.gpo.gov/fdsys/

Copies of the completed PASRR Level II are forwarded to the referring agency, facility, AHCCCS and if dually diagnosed (cognitive/intellectual disability and mental illness) to Arizona Department of Health Services, the primary care physician and the member and/or representative, with a notice of the member's right to appeal the determinations.

The Division is responsible for ensuring that appropriate level of care and medical services are provided to those members who have been diagnosed prior to their 22nd birthday to have a cognitive/intellectual disability or a related diagnosis.

The Division's PASRR Coordinator is responsible for interpretation of the PASRR findings to the person or designated family member and/or representative if the applicant for admission or resident is incapable of understanding the PASRR findings.

ANNUAL REVIEWS ARE NOW REVISED REVIEWS AND WILL BE CONDUCTED WHEN: A significant change has occurred in the member's physical or mental condition. It is a federal requirement for a nursing facility to notify the state authority promptly when and if a significant change has occurred utilizing the Minimum Data Sets (MDS) guidelines for significant change requirements to ensure that all members with a cognitive/intellectual disability or related diagnosis continue to require nursing facility services and or specialized services. The Division's PASRR Coordinator **also** will search the data base every month and contact the facility to inquire if any significant changes have occurred to warrant a revised PASRR Level II. If no change has occurred, a letter is sent to confirm the conversation and is placed in the resident's file. If a significant change has occurred, pertinent information is gathered again and the resident is scheduled for a Revised Review.

A REVISED PASRR LEVEL II IS NOT NEEDED FOR RE-ADMISSIONS FROM THE HOSPITAL OR INTER-FACILITY TRANSFERS.

703.7 Cease Process and Documentation Situation

If, at any time during this process it is found that the member does not have a cognitive/intellectual disability or related diagnosis or has a principal/primary diagnosis of Dementia, Alzheimer's Disease, or any related disorder or has any condition identified in section B of the PASRR Level I, that situation will be documented and the process will be stopped. If the illness results in a level of impairment so severe the member could not be expected to benefit from specialized services the process will be stopped.

THE DIVISION WILL RE-ASSESS THE MEMBER WHEN NOTIFIED BY THE NURSING FACILITY OF AN IMPROVEMENT IN HIS/HER CONDITION.

703.8 Nursing Facility Level of Care Inappropriate

The nursing facility in accordance with the state authority must provide or arrange for the safe and orderly discharge of the resident in accordance

with 42 CFR 483.12 (a) 1-7, the member shall be prepared and oriented for discharge.

http://www.gpo.gov/fdsys/

Any members who are currently enrolled with the Division of Developmental Disabilities who have been found to be unsuitable for a skilled nursing facility should be informed of less restrictive placement options and when in agreement, discharged to a less restrictive setting. Their Support Coordinator must ensure that the Member Support Plan process is followed, including participation by the member or responsible representative, primary care physician, nursing facility staff, District discharge planning team and other relevant members.

703.9 Appeal Mechanism

The Division will ensure that the person or their designee is informed of the appeals process available to them: appeal of determination for members who are adversely affected (members for whom the screening process indicated that admission to nursing facility would not be appropriate) the appeals process must follow the guidelines contained in 42 CFR 431 Subpart E. The Division will also recommend appropriate placement alternatives.

703.10 Referral Designation

The Division will maintain case records for all Level II evaluations for a period of 5 years in accordance with 42 CFR parts 447.

http://www.gpo.gov/fdsys/

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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 <u>are not</u> 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), 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).

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.

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 with in 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.

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900 PLAN COORDINATION

901 Overview

This chapter describes how the Division Support Coordinator arranges for and coordinates services, both internal and external to the Division, to meet the needs of eligible individuals as identified in the Individual Support Plan/ Individualized Family Support Plan/Person Centered Plan (Planning Documents). For services funded by the Division, the chapter specifies authorizations including but not limited to prior authorization, requirements for cost effectiveness studies, waiting list procedures, referral and placement procedures, safety consideration for placements including emergency situations, responsibilities for coordinating acute care services with the Long Term Care health plan, requirements for obtaining services out-of-area, and discharge/transfer procedures. It also describes policies and procedures necessary to provide effective, coordinated services with other agencies and programs, such as Department of Child Safety (DCS), Adult Protective Services (APS), Regional Behavioral Health Authority (RBHA), the Arizona Department of Education (ADOE), Arizona Early Intervention Program (AzEIP), Arizona Health Care Cost Containment System (AHCCCS), Health Insurance Portability and Accountability Act (HIPAA), American Indian Health Plan (AIHP) and Children's Rehabilitative Services (CRS).

902 Responsibilities of the Plan Coordinator – Residential Placements

The Division Support Coordinator is typically the plan coordinator. In an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), the Qualified Intellectual Disabilities Professional (QIDP) is the plan coordinator. The responsibility of the plan coordinator is to assist members in accessing services by ensuring that services, activities, and objectives identified in the Planning Documents are arranged for and implemented.

At the time of placement, the Support Coordinator is responsible for the following:

A. If a member's behaviors pose a danger to residents or staff, the Division will share this information with the parents/ guardians of other residents in the home. The agency director, designee, or Division staff will only provide non-personally identifiable information to the guardian.

B. For a member currently in placement or using out-of-home respite and potentially at risk, the Support Coordinator along with the Individual Support Plan (ISP) team will identify the appropriate person to inform the family of the risk.

In cases of emergency placement, the checklists capturing potential safety concerns for everyone in the home must be available to the guardian/family of the member moving in.

903 Selection of Providers

The member or the member's representative may select a provider from a list of Qualified Vendors (QVs) or Individual Independent Providers (IPs). The Division will match the member with a provider able to meet the needs identified in that individual's Planning Documents.

While it is unacceptable for the Support Coordinator to select providers for the family/member, the Division is responsible for assisting the family/member with identifying criteria that will help narrow the list of available providers. The criteria are based on the needs and preferences of the family/member. It is acceptable for the Support Coordinator to contact the provider to help determine availability.

The Division has implemented a process and developed procedures for purchasing Home and Community Based Services (HCBS). The procedures apply to the selection of a provider of community developmental disability services. Professional organizations, professional independent providers or IPs who become QVs may be selected. For more information regarding QVs, purchasing services and IPs refer to Arizona Administrative Code (A.A.C.) R6-6-2101 through R6-6-2115 azsos.gov/public_services/Title_06/6-06.htm.

These procedures also apply to HCBS selection when:

A. A member who is new to the service system is seeking a provider.

B. There is a change in a provider requested in the Planning Documents at the time of the annual review. This request requires an explanation. The Division shall accommodate the request, to the extent appropriate and practical as determined solely by the Division.

C. The member or the member's representative requests a change outside an annual review. The member/responsible person must state in writing or must report to the Support Coordinator for incorporation into the Planning Documents the following:

   1. The rationale for changing providers

   2. A description of the opportunities given to the current provider to address the member's concerns

D. Any changes for members over the age of three must be documented on the *Changes in the ISP*.

E. For children in the Arizona Early Intervention Program (AzEIP) the chosen provider is documented directly on the Individualized Family Service Plan (IFSP), with the date and the responsible person's signature.

Individual Independent Provider Selection Process

The Individual Independent Provider (IP) selection process is designed to be self-directed by the member. Specific procedures shall be followed in the event a member/responsible person identifies or wishes to choose an IP. A fiscal intermediary shall be assigned if an IP is chosen by the member. The Division requires the use of a fiscal agent to manage the tax responsibilities and other employer obligations related to IP selection.

The fiscal intermediary for the member and family shall:

A. Work with the Division and the Arizona Health Care Cost Containment System (AHCCCS) to develop appropriate informational materials to assist members and their families with choosing an IP.

B. Work with the Division to successfully transfer funds and any necessary confidential information.

C. Maintain member and family information in a confidential manner and in compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations (See Records Management in this Policy Manual).

D. Provide direct easy access to customer representatives who can assist with answering questions and resolving concerns.

E. Pay claims submitted by IPs, including tax obligations.

F. Maintain a declining balance for each service for each member that is submitted to the member regularly.

G. Maintain a system that ensures that the member/family has an available reserve of support hours for each service provided.

H. Work with members, families and the Division to resolve any financial concerns.

When a family chooses an IP to provide authorized supports as cited in the Planning Documents the member/family shall:

A. Use a fiscal intermediary to act as their agent for payroll and tax purposes.

B. Hire, orient, and train each IP to deliver the support as authorized in the Planning Documents.

C. Review and sign each IP time sheet.

D. Track the hours of service used against the hours of service authorized.

E. Report any concerns to the Support Coordinator, and work with the fiscal intermediary and Division staff toward resolution.

The provider for each service shall:

A. Have a contract with the Division.

B. Work with the fiscal intermediary chosen by the member/family to complete all requirements.

C. Work with the fiscal intermediary and the Division to resolve concerns.

Although provider selection is intended to be self-directed by the member, service delivery and provider selection is further determined by:

A. The planning process initiated by the Planning Documents that identifies the need and timelines for services funded by the Division.

B. The Planning Team has the option of completing the *ISP/IFSP Individual Attributes Checklist* to assist in the IP match process. This checklist will be filed in the referral section the member's case file.

C. Services are reviewed and approved per the Division's statewide service approval process. The Support Coordinator initiates the service approval process within five (5) working days from the date of identified need and within the timelines of service need specified in the Planning Document.

D. The District will maintain a list of IPs for the member/responsible person's consideration. Identification of the Individual Independent Provider is recorded on the Planning Documents.

E. The District designee completes the *Rate Assessment* with the member/responsible person. The assessment is filed in the referral section of the member's case file.

F. Once the service is approved, the Support Coordinator or designee documents the member/responsible person's choice of provider and follows the District's authorization process.

Qualified Vendor Selection Process

When a member/family identifies or wishes to choose a Qualified Vendor (QV), the following process is implemented:

A. The planning process identifies the need for services funded by the Division.

B. The Planning Team may complete the *Individual Attributes Checklist* that is optional for the QV match process.

C. The member/responsible person indicate whether they will contact the potential providers to assess availability or if the Support Coordinator or designee will assist. The Support Coordinator documents the choice.

D. Services are reviewed and approved per the Division's statewide service approval process. The Support Coordinator initiates the service approval within five (5) working days from the date of identified need. If services are denied, a *Notice of Action* form must be completed and processed.

E. The District shall maintain a Qualified Vendor directory that includes objective and factual attributes. This information will be used to assist the member/responsible person in selecting a QV.

F. Support Coordinators and Division staff are not permitted to recommend any specific provider. If the Support Coordinator or Division staff is asked to make a recommendation regarding a provider, this request cannot be granted. The Support Coordinator must explain to the member/responsible person that the QV directory lists all of the providers who are certified as Qualified Vendors for the service needed. If the Support Coordinator or designee is delegated to confirm availability, he or she must be unbiased in contacting providers.

G. The member/responsible person identify the chosen Qualified Vendor.

H. The member/responsible person or Support Coordinator/designee will notify the provider of the service need and the member's attributes. The provider must make contact with the member/ responsible person or express interest in delivering services to the member within five (5) working days.

I. The provider selected by the member/family is documented in the Planning Documents. If the provider is identified outside of the Planning Meeting, this must be recorded on the *Changes in the ISP.*

J. For Arizona Early Intervention Program (AzEIP) eligible children the chosen provider is recorded directly on the Individualized Family Services Plan (IFSP), with the date and the responsible person's signature.

K. No change in the Planning Document is required for the fiscal Intermediary when changing providers outside of a planning meeting.

L. The Support Coordinator/designee verifies or provides contact information to the available provider and member/responsible person to facilitate the introduction of member and provider.

When the member/responsible person notifies the Support Coordinator of an approved provider:

1. The Support Coordinator confirms the provider and member/responsible person match.

2. The Support Coordinator documents the member/responsible person's choice of provider and follows the District's authorization process.

Vendor Call Process

When a member/responsible person does not express a preference for a specific provider, they may request a Vendor Call for Services to identify potential providers for home and community based services (HCBS). The Vendor Call for Services invites Qualified Vendors (QVs) to submit a response indicating their availability to provide an identified service.

The Division may transmit or post a Vendor Call for Services that includes:

A. Only non-identifying information about the member or group of members.

B. A summary of service needs as outlined in the Planning Document.

C. Any special accommodations that the member(s) requires, including behavioral health, transportation, health care, personal preferences, etc.

D. Positive attributes and strengths of the member, such as hobbies, favored activities, preferences and likes.

E. The desired timeframe for delivery of services.

F. The date when the Vendor Call Response is due.

G. To whom the response is submitted.

The Qualified Vendor shall submit a written response to the extent requested that outlines:

A. The experience and background to provide the requested service(s).

B. A written plan to meet identified needs described in the member's Planning Document.

C. A description of how any special accommodations will be met.

D. A timeframe by which the service will be delivered.

E. Any additional information responsive to the Vendor Call for Services.

The Division designee(s) shall review all Vendor Call Responses received within the requested timeframe. Responses shall be evaluated based on the QV's written response as to how it will meet the member's service needs and accommodations included in the Vendor Call for Services. Within fourteen (14) days of the response due date, the Division shall notify each QV whether or not the submitted response fulfills the need specified in the Vendor Call for Services.

The Division shall provide the member/responsible person with a list of providers that meet the needs of the member. Prior to making a selection, the member/responsible person may request to meet with one or more of the QVs listed. The Division shall provide at least 48 hour notice to the QV when scheduling the meeting.

For all residential and day program services, the Division shall provide the following redacted, non-identifying information to the Qualified Vendor:

A. The current Planning Document.

B. Any historical and behavioral information necessary for the provider to anticipate the member's needs.

C. Summary information from the Program Review Committee.

D. Serious incidents reviewed by the Human Rights Committee within the past year.

E. Behavior treatment plans .

F. Additional information specific to the member and his/her support needs.

If the member/responsible person have signed a Health Insurance Portability and Accountability Act (HIPAA) release, the documentation provided to QVs in response to a Vendor Call does not require redaction. Providers who request to review the entire member file may do so with the written permission of the member/responsible person.

A Qualified Vendor may withdraw its response to a Vendor Call for Services at any time prior to when the member/responsible person or the Division makes a final selection. The final selection will be documented by the District in an authorization transmitted formally to the vendor, noting service codes, rate of reimbursement, level of staffing, target dates, etc. After a final selection has been made, the QV may not refuse to provide the authorized services for the member based on the difficulty of supports needed by the member.

Random Auto-Assignment Process

When the member/responsible person is unwilling or unable to choose a provider, the Division's Business Operations Unit will randomly assign a QV.

Notification of Network Changes

The Division will notify members/families who receive services of discontinued contracts for personal care providers, attendant care agencies, etc. The Division will send a letter to the member/family fifteen (15) days after receipt of the termination notice by the Division.

904 Short Term Emergency Situations (Residential and Day Programs)

To protect the health and safety of a member, a Qualified Vendor (QV) must notify the Division within twenty-four (24) hours (including weekends) if an

emergency situation exists in which the provider is unable to meet the health or safety needs of a member.

The QV shall explicitly specify the need for increased staffing due to the emergency. Emergency situations may include but are not limited to: acute psychiatric episodes, suicide attempts, deaths in the immediate family, severe and repeated behavioral outbursts, acute and disabling medical conditions, evacuations, etc.

Notification of all emergency situations shall be made to the District Program Manager (DPM) or designee *and* the Central Office. The notification for increased emergency staffing must be honored if verification is present in any form that reasonably could be considered notification, including notification to after hour on-call, e-mail.

The DPM/designee shall provide written approval/denial of emergency increased staffing to the QV. When approving an extension for emergency increased staffing (maximum is an additional fifteen [15] calendar days), the DPM/designee shall take into account the needs of the member receiving services and the capacity of the provider.

If a provider believes an inpatient placement is appropriate, the local Regional Behavioral Health Authority (RBHA) should be contacted for evaluation/placement.

Resolution of Emergency Situations

Upon notification from the QV, the DPM/designee will notify the Support Coordinator of the emergency situation. Within fifteen (15) working days of notification of an emergency situation, the support coordinator shall convene a Planning Team meeting to recommend any changes, including whether there is a need for additional temporary staffing to provide for the health and safety of the member.

If a need for additional temporary staffing is recommended beyond the initial emergency authorization for increased staffing, the Support Coordinator shall notify the DPM/designee of the continued need.

Within thirty (30) working days of initial notification of an emergency situation, the Planning Team, including a Division resource manager/designee, shall develop a written plan to resolve the situation.

The plan for resolution must include:

A. The change in behavior or condition that precipitated an emergency situation

B. The actions being taken to assist member (medical or psychiatric appointment, arranging for positive behavioral support, grief counseling, etc.)

C. The projected date of completion for each step

D. The criteria that would indicate the additional staffing levels are no longer needed

The support coordinator shall provide the written plan of resolution to the District Program Manager/designee for review and approval.

Qualified Vendor Request for Informal Review

After selection by the member/responsible person or the Division, or implementation of a plan to resolve an emergency, the QV discovers that it cannot meet the needs of a member; the vendor may request an informal review by the Division. The QV shall submit this written request for review to the DPM and provide notification to the Central Office.

The DPM shall review the facts and provide the final decision in writing to the QV within 21 calendar days of the request for a review. If the DPM rejects the vendor's request, the DPM shall provide the QV with the reason for the decision.

If the DPM approves the QV's request to discontinue providing services to the member, the QV shall not discontinue service provision until an alternate provider is selected and the member is transitioned to the new provider.

A.A.C. R6-6-2110

azsos.gov/public_services/Title_06/6-06.htm

905 Referral and Placement in Services

Following completion of all authorization procedures the Support Coordinator shall contact the identified provider and arrange to initiate the service.

Prior to a member starting a service, the Support Coordinator shall send a copy of the Planning Documents to the identified provider.

Preschool-age children shall not be placed in a Child Developmental Foster Home without a stay-at-home parent, unless all other alternatives have been exhausted and the Assistant Director has given approval. There may be exceptions to this requirement for children whose cases have been transferred to the Division from

Department of Child Safety (DCS). All other alternatives include currently available Child Developmental Foster Homes.

The Division staff shall also make every attempt to develop an appropriate home if one is not available. The Assistant Director will consider the need for expansion of a Child Developmental Foster Home after the family's situation and family dynamics have been thoroughly explored. Child Developmental Foster Home expansion will not occur unless it is determined that the child can fully benefit from this placement, and that the quality of care and supervision of other members who reside in the home will not be adversely affected.

For members being placed in residential or day program service settings, the Support Coordinator shall also send to each provider the following information:

A. Demographic information that includes the member's name, address, telephone number, date of entry into the Division system, Focus identification number, legal competency status, language spoken and understood, name of parent/responsible person or next of kin (with address and telephone number), physician's name, address and telephone number, and Third Party Liability (TPL) information (company, policy number, etc.). Printouts of the appropriate Focus documents and/or Planning Documents should contain most of this information, and will be acceptable documentation for referral purposes.

B. Current and appropriate consents and authorizations.

C. Description of special needs and how these should be met (e.g., medical or behavioral), if not thoroughly documented on the most recent Planning Documents.

D. A copy of most recent physical examination.

E. Medical history, including results of Hepatitis B and tuberculosis tests, and immunization records, if available.

F. Current medications and medication history, if not thoroughly recorded on the most recent Planning Documents.

G. Copies of other assessments necessary to provide effective services, such as vision and hearing screenings, dental records, therapy evaluations, psychological evaluations.

In the event these records are not available, the Support Coordinator should assist the provider in scheduling appointments or obtaining the records needed to meet minimum residential licensing requirements.

For members being placed in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), a physician's order and the approval of the Assistant Director shall accompany the above information. The Assistant Director may delegate selective authority.

The Planning Team shall schedule a pre-placement meeting with the provider to introduce the member, review the Planning Documents and other records, and discuss any other information necessary to provide safe and effective services. The Support Coordinator shall coordinate and attend pre-placement meetings for residential and day program settings. The Support Coordinator shall determine the need to attend pre-placement meetings for other home and community based services on the circumstances of each case.

906 Service Provider Information, Authority and Notification

The Division shall disclose to a service provider in the Planning Document, and in all meetings resulting from a response to a Vendor Call for Services, any historical and behavioral information necessary for the provider to anticipate the member's future behaviors and needs. This includes summary information from the Program Review Committee, Unusual Incident Reports reviewed by the Human Rights Committee, and Behavioral Health Treatment Plans. The Division will redact the member's identification from this information.

Service providers are authorized to engage in the following activities in accordance with the member's Planning Document:

A. Administer medications, including assisting the member's self-administration of medications.

B. Log, store and dispose of medications.

C. Maintain medications and protocols for direct care.

The Department may establish procedures for items "A" through "C" listed above.

To protect the health and safety of a member, a provider must notify the Division within 24 hours if an emergency situation exists in which the provider is unable to meet the health or safety needs of the member.

On notification of an emergency, the Department shall hold a Planning Meeting within 15 days after notification to recommend any changes, including whether there is a need for temporary additional staffing to provide appropriate care for a

member, and shall develop a plan within 30 days after notification to resolve the situation.

Other Safety Considerations for Placements

Prior to any out-of-home respite or residential placement (including emergencies), the *Pre-Service Provider Information*, *Residential Transfer Checklist* , and any other pertinent forms shall be completed to gather general care information and identify potential safety concerns to prevent risk to the member, other residents, staff and the public.

The Planning Team shall complete the *Case Transfer* form as part of the pre-placement meeting.

The Planning Team will identify in the Planning Document appropriate means to deal with potential safety risks including, but not limited to training, inoculations, and staffing as needed.

The Planning Team, in consultation with law enforcement, Behavioral Health, the Department of Child Safety (DCS), or other members/agencies as appropriate, will identify planned responses to known problems prior to placement, and document them on the *Risk Assessment*.

907 Discharge Planning

Discharge planning is a systematic process for the transition of a member from one health care setting to another or the transition of a medically involved member from one residential placement to another. The key to successful discharge planning is communication between member, family/caregiver and health care team. Depending on the specific needs of the member, the following people may participate in the discharge planning process:

A. Member/family/caregiver

B. Primary care provider/specialist

C. Discharge Coordinator/Social Worker/Quality Assurance Nurse

D. Utilization Review Nurse (hospital, Division or Health plan)

E. The Division Discharge Planning Coordinator

F. The Division Support Coordinator

G. Other Planning Team members, as necessary

In order to ensure that Support Coordinators and District Nurses are aware of hospitalizations of Arizona Long Term Care System (ALTCS) eligible members, the Medical Services Representative will e-mail the Support Coordinator and District Nurse identified in Focus when notified of an admission. It is the responsibility of the Support Coordinator to notify the Division's District Nurse or Discharge Planning Coordinator of transfers of medically-involved members, or the hospitalization of a non-ALTCS eligible member.

The discharge planning process is applicable in health care settings, and in the transfer of a medically involved member from one Child Developmental Foster Home, Adult Developmental Home, Group Home, and Intermediate Care Facility for Individuals with an Intellectual Disability or Nursing Facility to another. The process will generally include the following activities:

A. Complete a Division Discharge Plan Assessment, e.g., nursing assessment

B. Review of discharge orders written by doctor

C. Ensure that the member/family/caregiver has received proper training to carry out the discharge orders

D. Ensure that all necessary equipment and supplies have been ordered and will be available when needed

E. Ensure that transportation arrangements have been made

F. Reinstate applicable service(s) that may have been interrupted, or initiate services now determined needed (update Planning Documents)

G. The District Nurse or Discharge Planning Coordinator will complete a *Utilization Review Nursing Worksheet – Health Care Services*, and send copies to the Support Coordinator and Health Care Services (HCS)

H. Notification and/or signatures as required on the *Utilization Review Nursing Worksheet – Health Care Services* form:

   1. Health Care Services Representative (District Nurse and/or Discharge Planning Coordinator)

   2. District Program Manager or designee (to be notified about all changes of placement)

3. Medical Director (to be notified by HCS of level of care changes)

4. The Division Assistant Director/designee (signature also required for placement in an ICF/IID)

Members with Medical Needs

Members are considered to be medically involved when they require two or more hours per day of skilled nursing care. Thorough discharge planning for people who are medically involved ensures continuity of a member's services when the member is moving from one setting to another. Placement and services should be appropriate and established prior to the member being discharged.

The Support Coordinator, District Nurse and/or the Discharge Planning Coordinator will work together to initiate the discharge planning process. Their communication can include a Planning Document. Convening a Planning Team meeting is at the discretion of any member.

The following procedures shall be implemented for all members who are medically involved:

A. The District Nurse will verify hospitalization notification and/or transfer intentions with the Support Coordinator.

B. The District Nurse or Discharge Planning Coordinator shall follow the hospitalization and keep the Support Coordinator updated on the member's condition and the concerns expressed by the member/family/caregiver.

C. A Planning Team meeting should be called prior to discharge for complex cases. The hospital discharge planner is considered the lead in this meeting, and should assemble the family/caregiver, attending physician, primary care provider (if possible), social services, the Support Coordinator and Division Nurse, the health plan utilization review nurse. Other disciplines may be included, particularly if their role influences the member's discharge status/planning (i.e., Department of Child Safety or Adult Protective Services).

D. If placement is an issue:

1. A nursing assessment will be updated/completed, to assess the nursing/medical needs of the member and identify the appropriate type of facility/residence.

2. If behavioral health is a need, referral to the Regional Behavioral Health Authority (RBHA) should be made by the Support Coordinator to initiate assessment and their participation in the discharge planning process.

3. Based on the Planning Documents, the Support Coordinator will then work with the appropriate staff to arrange for the facility/residence which will provide for the identified needs.

E. If the Division is expected to pay for an ICF/IID placement, a thorough review is required, including Health Care Services, before any admission is made. All placements in ICF/IID(s) must have the approval of the Assistant Director. These facilities are restrictive environments, therefore, placement is temporary and transitional, occurring only after the following alternative options have been eliminated:

1. In-home supports.

2. Individually Designed Living Arrangement.

3. Community based placements, i.e., Group Home, Child Developmental Foster Home (CDH) or Adult Developmental Home (ADH).

See Policy Manual for more information on ICF/IID.

A. For those members who are returning to an ICF/IID, the District Nurse or Discharge Planning Coordinator shall participate in the planning process. The entire planning process shall be completed before the discharge/transfer is made.

B. In the absence of a Planning Meeting, the District Nurse and/or Discharge Planning Coordinator will coordinate the discharge orders, caregiver training, equipment/supplies, home health care and transportation.

C. The Division Nurse or Discharge Planning Coordinator shall complete a *Utilization Review Nursing Worksheet – Health Care Services* upon discharge, and send copies to the Support Coordinator and HCS.

D. The Discharge Plan shall take precedence over any Planning Document objectives that are in conflict. If there is a conflict, a new Planning Document shall be developed as soon as possible. The member/responsible person, primary care provider or any other

attending physician involved shall resolve disagreements. The medical records and a summary of the disagreement may be sent to the Discharge Planning Coordinator to be reviewed. The Division's Medical Director may be contacted to review the case and assist in the resolution of the disagreement.

E. The member's primary care provider shall be given the opportunity to participate in the discharge planning and review the completed Planning Document.

Nurse Consultation to Determine Medical Needs

The District Nurse or Discharge Planning Coordinator may be contacted directly by the Support Coordinator to review a member's hospitalization or transfer plans to determine if medical discharge planning is needed. A *Utilization Review Nursing Worksheet – Health Care Services* should be completed by the District Nurse or Discharge Planning Coordinator and submitted with appropriate documentation to HCS and the Support Coordinator indicating if skilled nursing needs have been identified.

Members Without Medical Needs

For non-medically involved members who are being discharged from a hospital or skilled nursing facility, the following procedures shall be implemented:

A. The Support Coordinator shall assess for medical needs prior to discharge. If needed the District Nurse or Discharge Planning Coordinator will complete a *Nursing Assessment - Health Care Services* to plan and recommend an appropriate level of care.

B. If the member is non-medically involved, the Support Coordinator will:

1. Ensure that training of caregivers has taken place.

2. Assess for and authorize in-home supports as appropriate.

3. Make arrangements for equipment, supplies, medications, etc. through appropriate systems.

4. Ensure that follow-up instructions are in place.

C. In those situations where a residential setting will change, the Planning Document process shall be an essential part of discharge planning.

Foster Care Discharge Planning

For all members in foster care, the following discharge planning procedures shall be implemented:

A. The Support Coordinator, District Nurse or Discharge Planning Coordinator will assess for medical needs prior to hospital discharge. If medical needs are present, the nurse will complete a *Utilization Review Nursing Worksheet – Health Care Services*, and coordinate a plan of care, training for caregivers, and equipment and supply needs. A *Nursing Assessment - Health Care Services* will be updated/completed to determine home based nursing services and/or placement needs.

B. The District Nurse or Discharge Planning Coordinator must be notified:

   1. Prior to any foster child being admitted to or discharged from an ICF/IID or Nursing Facility (NF).

   2. Prior to any foster child that is medically involved and/or receiving home based nursing services or being considered for a change in placement.

C. The Planning Team must be notified prior to this change of placement. The District Nurse or Discharge Planning Coordinator will complete the *Utilization Review Nursing Worksheet – Health Care Services*, and coordinate plan of care, training, and equipment and supply needs. The District Nurse or Discharge Planning Coordinator will notify HCS of changes in placement. The Support Coordinator will notify the District. Specific to an ICF/IID admission, the personal authorization of the Assistant Director (or designee) is required.

D. Children in foster care whose cases have been transferred from DCS to the Division may also require the participation of court appointed special advocates, attorneys, guardian ad litems or other professionals from the juvenile court.

Discharge/Transition of Members with Severe Behavioral Challenges

When a member with severe behavioral health challenges is placed into a psychiatric hospital setting, the Support Coordinator will begin discharge planning immediately and District Personnel will attend a hospital staffing within seventy-

two (72) hours. Support Coordinators should, if possible, attend all subsequent hospital staffings. Prior to discharge, the Support Coordinator will:

A. Involve staff responsible for contracting with Provider Agencies as soon as possible;

B. Begin the appropriate Planning Process; and

C. Ensure that staff from the behavioral health system is invited to all planning sessions.

Use of the *Discharge/Transition Checklist for Individuals with High Risk Behavioral Challenges* is mandated when planning discharge from an inpatient setting for members with severe behavioral challenges. The form can also be used when someone with behavioral challenges moves from one setting to another. The form is intended to provide reminders to the team about important areas to consider and should be used to plan for the discharge/move.

The *Emergency Contact Plan* is intended to record very basic information about the person that would be helpful to others coming in to assist in a crisis situation, such as crisis mobile team members or police officers. The form should be completed at the discharge/transition-planning meeting and updated as necessary. The representative from the behavioral health system should assist in filling out the form and the same information should, if possible, be on file with the RBHA. The *Emergency Contact Plan* should be kept in an easily accessible place in the setting, but it should never be posted.

The *Emergency Contact Plan* does not take the place of the Behavior Treatment Plan. Begin development of the behavior treatment plan prior to discharge, so that the person is discharged with at least a rough draft of the plan that eventually gets submitted to the Program Review Committee. This initial plan may be called a "crisis plan." It should have information about precursors/antecedents and creative strategies for preventing challenging behaviors. It should give staff ideas for teaching replacement behaviors, and it should let staff know whom to call when a crisis occurs.

908 Residential Placements for Educational Reasons (A.R.S. § 15-765)

A.R.S. §15-765 allows for residential placements for children for educational reasons. It is not intended to provide long term or permanent residential placements for children. These placements should be for a limited period of time and only for the purpose of accomplishing specific educational goals that promote the child's ability to benefit from a special education program in a less restrictive

environment. A.R.S. §15-765 www.azleg.state.az.us/arizonarevisedstatutes.asp requires that residential placement be made for educational reasons only and not for other issues, such as family matters.

In the event the child may need some level of intervention beyond what is available through the Local Education Agency, a representative from the school should collaborate with the family or legal guardian to identify resources available to the child, This may include services covered by either private insurance or the Arizona Health Care Cost Containment System (AHCCCS) behavioral health benefits. If the child is currently not enrolled in AHCCCS but may be eligible through Title XIX/XXI (KidsCare), the Public Education Agency should assist the family in the enrollment process.

When an out-of-home placement is considered, priority should be given to placement in the home school district so the child can either maintain placement or transition into the district when specific behavioral or educational goals have been met. Exceptions may exist for children with unusually complex educational needs that cannot be met in the home district, for example, in remote areas of the State. However, these reasons must be clearly documented before the placement is approved.

When the Individual Education Program indicates that out-of-home placement for educational purposes may be necessary, the Support Coordinator shall immediately notify the Division District Program Manager (DPM) for involvement in the placement process. If placement is to be made out of the Division District where the child resides, the Support Coordinator/originating District Program Manager (DPM) must contact the District Program Manager (DPM) in the receiving District in order to facilitate appropriate placement and services.

When requesting residential services for educational reasons through the Division, the following documentation must be provided by the requesting school district to the Support Coordinator. Copies of this documentation shall be placed in the case file. This information is then forwarded to the DPM and Central Office.

A. A letter of request for services.

B. Parental signature for consent for evaluation and services.

C. A copy of the Individual Education Program (IEP) that includes:

1. Documentation of least restrictive environment considerations, including the specific reasons why the child cannot be educated in a less restrictive environment.

2. Specific services requested, such as residential placement.

3. Length of time for the placement. For example, six months, one school year.

4. The exit criteria (goals which when accomplished will indicate that the child is ready to return home or to the home school district).

D. If the member is being placed outside the state and is eligible for the Arizona Long Term Care System (ALTCS), the Arizona Health Care Cost Containment (AHCCCS must approve the placement in advance.

Incomplete documentation of the educational reasons for requesting residential placement will result in a delay. The Division Central Office may also deny the request.

Following approval and placement in an out-of-home setting for educational purposes, the need for placement shall be reviewed every 30 days after placement by the respective planning processes (Individual Education Program/Individualized Family Services Plan/Person Centered Plan meetings). The results of the review shall be documented in the progress notes. Requests for continuation of the placement must be submitted to the Division Central Office for approval by June 15 of each year. Requests for continued placement shall contain the same information and be submitted in the same manner as required for initial placements.

During the 30-day reviews, all parties shall consider progress according to the goals and objectives of the treatment plan and the Individual Educational Program (IEP) exit criteria. Each review shall also include a discussion surrounding the type of educational and behavioral health supports that would be needed to return the child to a less restrictive placement.

Anticipated transitional supports shall be discussed during the 30-day reviews. The Local Education Agency and the Regional Behavioral Health Authority (RHBA) shall both strive to ensure that the necessary educational and Title XIX/XXI behavioral health supports shall be available to the child and family at time of discharge.

Any proposed change in a residential placement for educational reasons must be made through the IEP review process. Changes in placement must be consistent with the goals of the child's IEP and recommended by the team. Placements may not be changed for reasons other than those related to educational purposes.

When a child's parents move to a new school district, the District that placed the child must notify the new school District of the placement arrangements.

The new District has the responsibility to review the appropriateness of the placement and use the IEP process to make any recommended changes.

When a child is promoted to a high school district, the District that placed the child must treat the promotion as a change of placement and must include the high school District in the IEP review process.

When the team determines that a child needs Extended School Year Services, no change in the residential placement may be made unless specified in the Individual Education Program (IEP).

http://www.azleg.state.az.us/arizonarevisedstatutes.asp

Transition to the Community

A. When the child's treatment goals and the IEP exit criteria have been met, the Division, Local Education Agency, Regional Behavioral Health Authority (RBHA), family or legal guardian and residential provider shall collaborate on the necessary planning for transition to a less restrictive setting. At that time, the IEP shall be revised and the treatment plan updated.

B. The Division, Local Education Agency, RBHA and family or legal guardian shall coordinate with the residential facility provider to schedule a discharge date.

C. The Division, Local Education Agency and the RBHA shall ensure the agreed upon educational and Title XIX/XXI behavioral health supports are in place for the child and family upon discharge.

Post-discharge, the Division, the Local Education Agency and the RBHA shall continue to monitor the child's status in the less restrictive placement. Communication between the Division, the Local Educational Agency and the RBHA shall continue in order to monitor and support the child's successful integration in the new setting.

Preschool Transition

The Division has entered into an Intergovernmental Agreement (IGA) with the Arizona Department of Education (ADOE). The purpose of this agreement is to ensure that children reaching their third birthday complete the transition from services provided by the Division's early intervention programs to an appropriate public education with minimum disruption and stress on the child and family.

Oversight Responsibility

The Division partners with the AzEIP (Arizona Early Intervention Program) service provider agencies and the early intervention service providers.

The Arizona Department of Education (ADOE) oversees compliance with Part B of the Individuals with Disabilities Education Act of all public education agencies.

Agency Responsibilities

Notification by the Arizona Early Intervention Program (AzEIP)

The Support Coordinator is responsible for notifying the Local Education Agency and the Division by February 1 of each school year, of children who will be transitioning in the upcoming 16-month period (February through May of the following year), by preparing a list of children which will contain only directory information consistent with the Family Educational Rights and Privacy Act regulations found at 34 Code of Federal Regulations §§99.31 and 99.37 (http://www.whitehouse.gov/OMB/). Directory information consists of the child's name, address, telephone number and date of birth.

On September 15 of each school year, the Support Coordinator will give an updated list of children transitioning between September and May of the school year. The directory information may be shared between the AzEIP and the Local Education Agency without parental consent. This exchange of directory information is allowed in order to comply with the Federal Child Find requirements. All other family and child information may only be shared with parental consent.

For each child receiving Division early intervention services, the Support Coordinator is responsible for requesting written parental/guardian consent to release information.

Individual Education Program (IEP) Conference/Individualized Family Services (IFSP) Conference

The Individual Education Program conference is a meeting to be held no later than the age 2.6 to age 3 to determine appropriate programming. The Individual Education Program conference can be held at the same time as the preschool eligibility and multidisciplinary conferences. The Individual Education Program conference can also be held in conjunction with the individualized family services plan conference. The required participants for the Individual Education Program conference are the same as the required participants for the preschool eligibility conference/multidisciplinary evaluation team conference.

Local Education Agency Responsibilities

If the child is eligible for special education, the local education agency shall:

A. Conduct the combined IEP /IFSP conference.

B. Obtain parental/guardian consent and offer services to the child.

Residential Placement for Other than Educational Purposes

Upon request and approval, people with developmental disabilities under the age of 18 may need out-of-home residential placement in a Division contracted setting.

These reasons relate directly to the child's disability and the genuine inability of the parents to meet the child's needs in the family home, even with the provision of available supports by the Division.

Pursuant to A.R.S. §36-552(C); §36-558(A) and §36-560(B), www.azleg.state.az.us/arizonarevisedstatutes.asp the provision of State funded services is subject to available appropriations. This necessitates formal consideration and strict budget control by the Assistant Director of all requests for voluntary out-of-home placement for children under the age of 18. Foster Care funds may not be used for voluntary out-of-home placements.

The Assistant Director will decide whether or not a voluntary out-of-home placement is in the best interest of the child based on the circumstance of the case. This decision is contingent upon available funding. This decision is also based on the following criteria:

A. After specified procedures, the parents and other members of a school district Individual Education Program (IEP) team, in consultation with the Division, have determined that the child requires a time limited out-of-home placement in order to receive an appropriate special education (A.R.S. § 15-765). www.azleg.state.az.us/arizonarevisedstatutes.asp

B. The child is eligible for and receiving Title XIX behavioral health services and a multidisciplinary team, in consultation with the Division, and with the approval of the parents, has determined that the child requires a Department of Health Services (DHS) contracted setting, e.g., a residential treatment center or a therapeutic group home, as a result of behavioral health problems.

C. The parents and the Individualized Family Services Plan/Person Centered Plan/Child and Family Team Plan determine the child needs

short or long term out-of-home placement after (1), (2) and (3) have been tried or ruled out and if (4) is true (see below):

1. Reasonable efforts by the Division have been made to provide in-home supports and there is documentation that the parents have actively participated and that the supports have not been successful in meeting the child's needs.

2. Parents have explored the option of placement with a relative, with the provision of available supports from the Division and it has been ruled out as a viable option.

3. Alternatives such as part time out-of-home placements have been created and tried without success.

4. Services needed by the child cannot be provided in the home or the community.

Based upon recommendations from the Individualized Family Services Plan/Person Centered Plan, verification that the above criteria have been met or have been determined to be inappropriate and certification as to availability of funds, the District Program Manager (DPM) may recommend the placement to the Assistant Director who must approve the placement.

Responsibilities of the Parents/Guardians:

A. Parents/guardians must be in agreement with out-of-home placement.

B. Parents shall visit and approve the proposed placement prior to a decision being made.

C. Parents shall sign an agreement to contribute financially to the placement. The amount of parental contribution will be determined on a sliding fee scale based on income. If the child receives Supplemental Security Income (SSI), the contribution to the residential costs will equal 70% of the monthly benefit, in addition to the parental assessment. In such cases, the monthly SSI benefit will not be included in the family income when determining the amount of parental assessment.

   In addition, parents will provide those items, such as clothing and other personal expenses, which typically are not included in the rate paid to providers of residential services.

D. Parents shall visit the child and/or take the child home for visits on a regularly scheduled basis. The frequency of the planned visits shall be determined by the parents and the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and will be documented.

E. Parents will continue to actively participate in the medical care of the child and in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan and Individual Education Program processes.

F. Parents may request a gradual transition into the placement.

G. Parents whose cases have been transferred from Department of Child Safety (DCS) have different responsibilities as determined by child welfare laws and the court.

Responsibilities of the Division:

A. Prior to a placement being made, the Division shall create agreements with the provider for the parents and siblings to visit on a regularly scheduled, frequent basis as determined by the Planning Documents.

B. Children should be raised within families. Consequently, the Division shall make reasonable efforts to place the child in a setting appropriate for the child that is as homelike as possible and in as close proximity to the family as feasible. This home must be prior approved by the family.

C. Upon parent request, the Division will plan for and arrange, in coordination with the Planning Team (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan Team), a gradual transition into the out-of-home placement.

D. The Division Support Coordinator shall visit and assess the appropriateness of the out-of-home placement prior to the child being placed.

E. The Division Support Coordinator shall visit the child in the residential placement within 10 days of placement and at least quarterly thereafter. This is the minimum visitation frequency, even if Arizona Long Term Care System (ALTCS) guidelines allow for less frequent service plan reviews.

F. The need for continued out-of-home placement will be reviewed and documented during the ALTCS service plan reviews and semi-annually at the time of the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan review.

G. Since the ultimate goal is for the child to return to the family when possible, the District Program Manager (DPM) shall review and report to the Assistant Director the status of each child in out-of-home placement at least every six months. The review shall ensure that the child's needs are being met in the placement, that the need for placement still exists, that circumstances still meet the placement criteria, that both the Division and the parents have met their responsibilities and that the child has not been abandoned as defined in A.R.S. § 8-546.

http://www.azleg.state.az.us/arizonarevisedstatutes.asp

H. The Division, in coordination with the Planning Team, will facilitate the child's return home as circumstances permit.

In the event an appropriate placement cannot be made within the boundaries of the child's current school district, the Division Support Coordinator should consider the ability of the receiving school district to meet the child's educational needs when planning for the residential placement. In such instances, the Support Coordinator shall immediately contact the Special Education Director of the school district in which placement is being considered. As soon as possible, the Support Coordinator shall provide the following information to the Special Education Director:

A. The target date the child will establish or change residence.

B. A copy of court order(s) establishing dependency, legal guardianship or surrogate parent, if appropriate.

C. All relevant psychological, educational and medical records including the most recent psychoeducational report; relevant social and developmental history, immunization record, medical certification within the last three years of a physical disability, visual impairment or hearing impairment. Current educational records including the Individual Education Program (IEP), placement statement and therapy reports/evaluations if a psychoeducational report does not exist, the school district is responsible for completing the evaluation.

Within 5 days of receipt of this information, the Special Education Director should contact the Division Support Coordinator to set a date for a multidisciplinary

conference and initiate the evaluation and Individual Education Program (IEP) processes for special education placement. If a parent, legal guardian or legally appointed surrogate parent is not available to consent to evaluation and special education placement, the Division Support Coordinator shall work cooperatively with the local education agency's Special Education Director to obtain appointment of a surrogate parent.

The Division Support Coordinator shall participate in IEP meetings for children in residential placements operated by or financially supported by the Division, but may not legally consent to special education placement.

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1200 PAYMENT FOR SERVICES

1201 Third Party Liability

Third party liability (TPL) is any funding source other than the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). It includes medical insurance, e.g. Medicare, CHAMPUS or TR ICARESS, Blue Cross/Blue Shield, etc. It also includes any benefits or settlements a person has as the result of an accident. It may also include eligibility for other programs such as Children's Rehabilitative Services (CRS), Arizona Health Care Cost Containment System (AHCCCS), or county funded services.

DES/DDD is required to bill any third party for all covered services for all individuals eligible for services through DES/DDD. A member/responsible person is required to provide third party insurance information when requested.

1202 Client Billing

Financial Contribution

Members receiving Home and Community Based Services (HCBS) may be required to make a financial contribution to the cost of their care.

Members receiving state funded services who have a trust, annuity, estate, or assets exceeding $2000 will be required to make a financial contribution for the actual cost of programs and services provided by the Division. When billing a trust, the Division is not limited to trust income and can also bill the trust corpus.

Members who meet the financial eligibility requirements for federal Social Security Supplemental Income benefits or the financial eligibility requirements for ALTCS are not affected by this requirement.

Members and responsible parties affected by this financial contribution requirement may make applications to AHCCCS for ALTCS eligibility determination. If eligible for ALTCS, the member will not receive a bill for the cost of programs and services, except a member may be billed for room and board.

Financial Contributions and Billing for Residential Services

A. The financial contribution for a member receiving residential services is based on the total amount of income and monthly benefits the member receives. For purposes of this policy, “residential services” means room and board.

1. The required financial contribution is a maximum of 70% of the

member's income and monthly benefits the member receives, but shall not exceed the actual cost of room and board.

2. When the member's personal savings exceeds the maximum limit allowed by the federal agency providing the monthly federal benefits, the billing amount is:

   i. For the ALTCS member, the actual cost of room and board services until the member's personal savings drops below the maximum allowable limit;

   ii. For the non-ALTCS member, the actual cost of all services, including room and board, until the member's personal savings drops below the maximum allowable limit.

B. The Department will notify the financially responsible person of the amount the member is required to pay each month for room and board costs.

C. The financially responsible person shall pay the monthly bill, or may contact the Division to request one or more of the following: a financial review, an Administrative Review, or a reduction in the amount billed based on hardship to the member.

Financial Review

A. The financially responsible person may contest the figures or method used by the Division in calculating the amount by requesting, verbally, or in writing:

   1. An informal business review. An informal business review is conducted by the Division's Business Office, and may be requested at any time ten (10) or more business days prior to the payment due date; the Division will make its best efforts to respond within ten (10) business days from receipt of the request. There is no right to appeal the response to an informal business review, only the decisions that results from of an Administrative Review may be appealed as described below; or

   2. An Administrative Review as prescribed by Arizona Administrative Code (A.A.C.) Title 6, Chapter 6, Article 18, with appeal rights as prescribed by A.A.C. Title 6, Chapter 6, Article 22. The financially responsible person may request an Administrative Review at any time within thirty-five (35) days of the date payment is due by submitting a request to the Divisions Office of Compliance and Review.

B. The financially responsible person may request an Administrative Review without requesting an informal business review.

C. Any request for consideration based on the member's personal obligations or expenses shall be resolved under a Hardship Reduction Request described below.

Hardship Reduction Request

A. Any person financially responsible for the cost of care of a member may submit a *Hardship Reduction Request* to the Assistant Director. The request must be accompanied by supporting documentation as described below.

B. Consideration for a hardship reduction will be given for the following expenses:

1. Medicare Part D prescription drug co-payments, when submitted with proof of out-of-pocket expenses.

2. Amounts ordered by a court for restitution, child or spousal support, when documentation of the order is submitted.

3. Amounts paid for services provided by and items prescribed by a licensed health care professional, when documentation of the expenses supporting the request and denial(s) from third party payers or other potential sources of assistance are submitted.

4. Expenses for an extraordinary circumstance that affects the consumer's health and safety when documentation of the amount of the expense and the effect on the consumer's health and safety if the expense is not incurred is submitted.

5. Cost of a prepaid burial or cremation plan when supported by documentation of the cost and the length of the payment period.

C. The Division will review requests that include current documentation of the expenses supporting the request and will issue a written determination that:

1. Approves a temporary reduction of the billing amount for up to 12 months; or

2. Denies the request.

D. The financially responsible person who disagrees with the hardship determination may request an Administrative Review. This request must be received by the Division within 35 days after the date of the Division's hardship determination.

E. The Division reserves the right to amend or rescind a reduction of costs if the consumer's financial circumstances change or have been misrepresented.

F. Upon request by the Division, the financially responsible person shall provide verification that the expense for which a hardship is granted has been paid.

1203 Administrative Review/Appeal and Hearing Rights

A. The Division will issue a written decision within thirty (30) calendar days from receipt of the request for Administrative Review. Appeal of this decision is available as prescribed by A.A.C. Title 6, Chapter 6, Article 22 (R6-6-2201 et seq.).

B. If Administrative review is based on notice of an increase in the monthly billing amount, the billing amount shall not increase until the Department has issued its final decision.

C. If the Administrative Review decision or an appeal of an Administrative Review decision results in affirmation of the original order in whole or in part, the monthly billing liability shall be retroactively effective from the date of the original notice of the billing amount. The person liable for the cost of care shall pay all amounts as stated in the original notice, as adjusted (if any adjustment in the amount is made by Administrative Review or the appeal). The Department's final decision on the billing amount will be retroactively effective beginning with the month in which the request for Administrative Review was made. Failure to pay the amounts owed may result in termination of services.

Department of Economic Security – Division of Developmental Disabilities

Policy and Procedures Manual

Chapter 1300 - Management of Consumer Funds

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1300 MANAGEMENT OF CONSUMER FUNDS

1301 Overview

This chapter explains Department of Economic Security (DES) policies for safeguarding, using, and investing funds for consumers in the Division of Developmental Disabilities (Division).

1302 Definitions

a. Consumer Funds – Funds entrusted to an individual or agency for safeguarding and investment. The requirements for this are found in the instrument establishing such funds, and by Division Policy and Internal Instruction Manuals. Funds include cash, checks, money orders, petty cash funds, change funds, bank accounts, savings accounts and investments.

b. Consumer Fund System - The systems used by the Division to maintain and track consumer funds.

c. Fiduciary Capacity - A person who also handles consumer funds is acting in a fiduciary capacity. He/she is responsible to properly and faithfully account for all consumer funds received by him/her. They may include any employee of the State of Arizona or private provider under contract.

d. Individual Spending Plan - A plan designed for each consumer living in a community residential setting or for whom the Division is the representative payee. The Planning Team process creates the plan. This plan dictates the amounts and purposes for which each consumer's money is spent.

e. Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Document) - A document developed by a Planning Team identifying needed services. It also includes the goals and objectives to be attained. The Planning Document directs the provision of safe, secure and dependable active treatment in areas necessary for individuals to achieve full social inclusion, independence and personal and economic well-being.

f. Personal Spending Money - Discretionary funds and allowances provided to consumers.

g. Railroad Retirement Annuities and Pensions - A comprehensive benefit program for railroad employees that have retired and includes their families and survivors. It was created in the 1930's. For more information on this benefit, contact the Railroad Retirement Board and request form IB-2.

h. Representative Payee - A representative payee is an individual or organization that receives Social Security and/or SSI (Supplemental Security Income) payments or other benefits for someone who cannot manage or direct the management of his/her money.

When no one is willing or able to perform the duties of the representative payee, the Division shall request that the Social Security Administration appoint them to become the representative for the consumer. When the Division is the representative payee, the Support Coordinator is responsible for the management of the consumer funds as directed by the Planning Team (Individual Support Plan/Person Centered Plan).

i. Residential Services - Includes Room and Board and daily Habilitation. Examples include: Habilitation Services - with Room and Board; Habilitation, Child or Adult Developmental Home; Habilitation; Nursing Group Home; Habilitation, Community Protection; Residential Room and Board, etc.

Because Residential Room and Board is not a reimbursable service under Title XIX, it is the only residential service that is billable under Administrative Rule R6-6-1204. (http://www.azsos.gov/public_services/Title_06/6-06.htm)

All other services that a consumer might receive in out-of-home care such as therapies, hourly support programs, day programs, etc., are not considered residential services.

J, Social Security Benefits:

1. Social Security (SSA, Title II) is a social insurance program that protects workers and their families (dependents or survivors) from loss of earnings because of retirement, death or disability of the wage earner. A worker's spouse or children may become eligible for Social Security if the worker becomes disabled or dies. The amount someone receives depends upon the age of the wage earner, the length of time worked and the amount they earned from which FICA taxes withheld.

Benefits are based on the insured's earnings. Persons receiving benefits cannot be disqualified because of income or resources. Persons become Medicare eligible after two years. Benefits are not affected by whom you live with or where you live.

2. Supplemental Security Income (SSI, Title XVI) is a federal income maintenance program for the aged, blind and disabled persons with few or no resources. The person must be blind or disabled or 65 or older, have limited income, and cannot have over $2,000 in allowable resources.

K. Veterans' Benefits - Benefits payable to surviving spouses and dependents of military personnel who die while in active military service and to survivors of veterans who die after active service.

1303 Consumer Fund System

When consumers need assistance in handling their funds, but no other responsible party is available, the Division applies to be the representative payee for these consumers. The responsibility of being representative payee requires the Division to have policies and procedures that direct the Division on how to maintain these funds and how these funds are to be used.

The Consumer Fund System Manager acts in a fiduciary capacity and is responsible for the funds under his/her control. Black's Law Dictionary, sixth edition states:

> "One is said to act in a fiduciary capacity or to receive money or contract a debt in a fiduciary capacity, when the business which he/she transacts, or the money or property which he/she handles, is not his/her own or for his/her own benefit, but for the benefit of another person, as to whom he/she stands in a relation implying and necessitating great confidence and trust on the one part and a high degree of good faith on the other part. The term is not restricted to technical or express trusts, but includes also such offices or relations as those of an attorney at law, a guardian, executor or broker, a director of a corporation and a public officer."

When the Division becomes the representative payee for the consumer funds, the Division sets up special accounts for these funds. These accounts are called the "Consumer Fund System" and are composed of:

a. Social Security Benefits (SSA)

b. Social Security Income (SSI)

c. Wages earned by the consumer

d Railroad Retirement (RR)

e. Veteran's benefits (VA)

f. Revenue from personal trust funds and estates

g. Monetary gifts and other sources

h. Earned interest

1304 Policy

This policy applies to all Division and contracted provider personnel involved with Division consumer funds if the Division is representative payee.

The Division will not be the representative payee when:

a. The Planning Team (Individual Support Team/Person Centered Plan team) determines that the consumer can learn to manage their own funds

b. There is a guardian, family member or other interested payee, other than a paid provider, willing and able to serve in that capacity and who is approved by the Social Security Administration.

A paid provider shall <u>not</u> be representative payee for a consumer.

As an exception to this, Independent Providers who are also family members may be a representative payee for a consumer.

Service provider and Division contracts specify that providers develop internal policies regarding consumer funds. These provider policies must be consistent with Division policies and appropriate state and federal regulations. These provider policies

are subject to Division approval during contract negotiations and subject to periodic review by Division staff.

This policy specifically prohibits a provider from establishing a bank account (other than the standard provider/consumer personal ledger) for a consumer.

The provider shall not establish or be included on a joint account for a consumer nor establish any account where the provider or provider staff has access to the consumer's funds.

Money paid out of the consumer accounts administered by the Division is by specific direction of the Support Coordinator as developed by the Planning Team. Supervisory and management approval is required. Consumer Fund System disbursements require a “Request for Funds” form.

The Division should not maintain an account for the consumer's benefits while another person (relative, friend, etc., but not a provider) maintains an additional account for the consumer's wages. Separate accounts make it difficult to assure that the individual's financial eligibility level for benefits or Title XIX services is not exceeded.

If someone other than the Division is maintaining an additional account (e.g. wages) for the consumer, the Division shall recommend that this person should become the representative payee to keep all the consumer's funds in one account **unless there are reasons why this person cannot or should not be the representative payee.**

1305 Responsibilities

a. District Program Administrators/Mangers are ultimately responsible for the proper use of the consumer funds.

b. The Division of Developmental Disabilities Business Operations will:

1. Ensure training, assistance and technical guidance is provided to all employees responsible for consumer funds.

2. Exercise good judgment and due diligence in the administration of consumer funds.

3. Audit and provide administrative assistance to review activity related to consumer funds.

c. Confidentiality will be maintained in accordance with Chapter 1800 of the Policies and Procedures Manual.

d. No Division employee shall offer assistance or in any way help an individual complete income tax forms unless they are the legal guardians for the consumer.

1306 Safeguarding Consumer Funds

a. Separate accounts:

1. A separate accounting shall be maintained for each consumer. This will show all funds received, or disbursed, and remaining balances.

2. Transactions posted to a consumer's account shall be traceable to an original source document, such as a *Request for Funds* form, a receipt, invoice/bill, etc.

3. Electronic transfers in or out of consumer accounts are not allowed.

b. Fund Transactions:

1. All funds received will be documented through the Consumer Fund System.

2. When a consumer transfers from one district to another, accountability for inter-district fund transfers will be documented. Signed receipt forms shall be used. This shall also be documented in the case record, See Chapter 900 for instructions..

   The District Consumer Fund Manager is to be notified in writing/e-mail of the transfer. The names of the sending and receiving responsible persons and the effective date of the transfer shall also be included.

3. Checks and other negotiable instruments received must be immediately endorsed with the restrictive statement:

AZ DEPARTMENT OF
ECONOMIC SECURITY, DIVISION OF
DEVELOPMENTAL DISABILITIES
(insert District identifier here) ACCOUNT
NUMBER (insert District Account
Number here) FOR DEPOSIT ONLY

4. Funds received are to be deposited in the designated bank account in a timely manner. Appropriate safeguards should be present while funds are being transported between the Division's facility and the bank.

5. The same person will not handle a transaction from beginning to end. If personnel and other cost considerations permit, cash and check handling and record keeping functions will be separated.

6. The Consumer Fund System Manager acts in a fiduciary capacity, which includes responsibility to account for all funds in the Consumer Fund System.

7. Insurance purchased for consumers in the Consumer Fund System such as life or burial insurance shall not list as beneficiary:

   a. the Division
   b. an employee of the Division
   c. a paid contracted provider
   d. an employee of a provider

   However, a family member who is also an employee of the Division or a provider may be listed as a beneficiary.

8. All transactions and record keeping will be done confidentially. Only those with a need to know are allowed to review and to work with the consumer's records.

c. The Support Coordinator shall submit a request to establish any new accounts. These requests are to be submitted to:

   1. The District Business Operations Manager or the District Program Manager for approval.

2. The request shall include the consumer's demographic data, effective dates, income sources and any requests for funds.

3. The District Consumer Fund Manager or designee will be notified once all the approvals are obtained.

1307 Consumer Funds Security

a. Consumer funds will be kept in a secure safe or locked location until deposited. When the Fund Manager leaves the work area, the safe or other location shall be locked.

b. Funds shall not be stored in desks, unlocked files, purses, or other places that are not secure, etc.

c. Computer access to consumer information shall be restricted by secure passwords. No one other than the fund manager and/or designee shall have knowledge of the safe key/combination or the password to secure files.

d. The District Business Operations Manager or designee shall reconcile consumer accounts monthly. The administrator of business operations must approve any exceptions.

1308 Disbursing Consumer Funds

a. All disbursements will be by pre-numbered checks.

b. All disbursements, except by authority of the District Program Manager/Administrator (DPM/DPA), must be authorized in the Individual Spending Plan.

c. All disbursements require the following:

1. Disbursements shall be documented by written requests for funds

2. Any request over $500 must be approved by the District Program Administrator/Manager or designee.

3. Documentation of the amount of each ongoing deduction for residential billings.

4. Excess funds are not to be used for non-approved purchases. If disbursed funds exceed the cost of the approved purchase, these excess funds shall be returned to the consumer's account with a reconciliation statement accounting for purchases. Anything under $5.00 may be returned to the consumer for personal use, unless the Support Coordinator requests otherwise

   The person processing an expenditure shall not be the payee of the check. Nor will the person maintaining accounting records or preparing checks also sign the checks

d. All pre-numbered checks will be accounted for monthly in the following categories to aid in the bank reconciliation process:

   1. Paid by bank (cancelled)

   2. Void

   3. Outstanding

   4. Suspense File: Cash or checks in the hands of third parties for the purchase of goods and services for consumers will be signed for and a suspense file established pending paid receipts. Suspense files will be cleared within thirty days after full payment for goods and services

e. It is the policy of the Social Security Administration that individuals shall be provided at least $30 monthly for their personal needs.

   1. Consumer personal spending money does not require receipts

   2. However, any personal spending money not paid directly to the consumer requires supporting documentation verifying the use of these funds. Those entities required to account for consumers funds shall maintain a log of all expenditures for each consumer.

f. All non-personal spending money disbursed from the consumer's account for any good(s) or service(s) in excess of $50.00, shall be verified within 30 days, by an itemized receipt. The receipt must show:

1. The vendor name

2. Date of purchase

3. A written description of the individual item(s) or services

District Program Administrators/Managers may establish a receipt limit of less than $50.00.

g. Until the properly supported receipt form is submitted, no further requests for that vendor or individual will be processed unless specifically approved by the District Program Administrator/Manager or designee.

h. It is permissible for a request to designate that several disbursements be made in the name of a consumer over a period of time. Examples include: monthly personal allowances, rent subsidy, etc. Such requests remain in effect until the Support Coordinator submits paperwork to change or cancel the request.

i. A disbursement request charging a consumer's account will not be honored unless that account has sufficient funds to pay the entire amount requested. The requesting party will be so notified and a modified request can be submitted.

j. All requests will be processed by the payment deadline set by the district business office or designated consumer fund system personnel.

1309 Consumer Funds - Provider Responsibilities

A person or agency providing out-of-the-home services for consumers may receive and maintain funds on behalf of the consumer for personal spending. These funds are to be recorded in a ledger maintained in the consumer's residence or agency's business office.

The agency or caregiver shall be required to provide proof of how the funds designated for the consumer were expended, at the

Division's discretion. See section 1310.c for stolen or missing funds.

1310 Ledgers Maintained by Providers

When the individual or service provider receives spending money from the Division, family, employment, or other sources on behalf of a consumer, they are to open and maintain a separate ledger for each consumer receiving these funds. The ledger is a financial record for each consumer, composed of a separate log and balance sheet with running totals. The balance is not to exceed $200. Funds in excess of $200 shall be returned to the District Consumer Fund Manager and deposited into the Consumer Funds System.

a. Funds can only be obligated and utilized for the consumer's personal needs; all funds received and expended must be accounted for in the ledger.

This ledger, maintained by the provider, will show:

1. all funds received: sources of those funds and the dates received,

2. all expenditures: what they were spent for, receipts, and dates funds were expended, and,

3. a running balance.

These records must be maintained for a minimum of seven years (ARS §41-1345 www.azleg.gov).

b. The ledger is to be sent to the consumer's Support Coordinator quarterly and provided for review at each Individual Spending Plan meeting or as frequently as requested by the Division and/or the guardian. Consumer funds are also subject to review by the assigned support coordinator or consumer's guardian.

The Support Coordinator will adjust the spending plan to assure that the Consumer funds that are maintained by the individual or provider do not exceed $200. Any funds in excess of $200 are to be returned to the district Consumer Fund System (CFS) Manager or designee for deposit into the consumer's account.

. Consumer funds cannot be loaned, given or provided in any way or manner to other consumers, provider staff, relatives or friends. Consumer funds cannot be used to purchase anything that is ordinarily required to be supplied by the service provider or the Division.

Consumer funds cannot be used to purchase insurance, burial plans, pay medical expenses, etc. for other consumers, providers, staff, relatives or friends.

The funds of several consumers may be pooled to make group purchases provided the Social Security Administration approval is obtained prior to the purchase (an example of a group purchase would be a large TV for a group home). The request for group purchases is to be submitted to the local Social Security Office for approval.

The provider must ensure that the consumer funds are used to meet the beneficiary's acceptable day-to-day personal needs including recreation and miscellaneous expenses as required by the Social Security Administration. The federal publication: Representative Payment Program, Guide for Organizational Representative Payees, Publication No. 17-013 is an excellent resource

c. Consumer funds shall be kept in a secure locked location.

Any funds discovered stolen or missing from the consumer's ledger or personal cash shall be the responsibility of the Provider or Qualified Vendor to replace within 10 working days of the discovery of the theft or missing funds. It shall also be reported to the consumer's Support Coordinator within 10 working days of the discovery.

d. These consumer funds are subject to audit. Any audit exceptions are the responsibility of the service provider for resolution and/or repayment.

e. The Support Coordinator shall follow Division and Social Security Administration policy and is responsible for the use of these funds.

The Consumer Fund Manager will provide technical assistance to the Support Coordinator when the consumer dies, moves to another setting or returns home. Obligations to the Division shall be the first consideration. The final disbursement of these funds will be processed by the Consumer Funds System Manager or designee as directed by the Support Coordinator.

f. Service providers shall not be representative payees for a consumer's benefits.

g. The Consumer Funds System Manager, or designee, shall notify the chain of command of the Division of Developmental Disabilities of any mismanagement, or suspected mismanagement, of consumer funds. The Administrator shall determine whether or not it is appropriate to refer issues to the Department of Economic Security Office of Special Investigations, and the Social Security Administration.

1311 Bank Reconciliation

Bank and checkbook balances will be reconciled monthly. The duties of reconciling the bank and Consumer Fund System balances and maintaining the accounting records will be separated. Bank, petty cash and change fund balances will be reconciled in consumer accounts monthly.

The Consumer Funds System Manager or designee shall send Monthly Consumer Fund reconciliation reports to the Division of Business and Finance, Accounting Office

Summaries of these reports are to be sent to the Business Operations Administrator.

A report on the number of Title XIX eligible individuals shall be sent monthly to local Arizona Health Care Cost Containment System office:

a. Those with balances over $1,500

b. Those with balances over $2,000

A report including all accounts with balances over $2,000 shall be sent to the District Program Administrator/Manager. This report shall be reviewed by management staff to ensure that District staff are working towards a spend down plan.

1312 Use of Consumer funds

Consumer funds are administered in accordance with the intent of the individual or entity providing the funds.

a. For economy and efficiency of administration, consumer funds should be pooled into one bank account. Separate records shall be maintained that identify each Consumer funds.

b. Funds in the pooled bank account in excess of current requirements shall be invested in accordance with the provisions of Chapter 1300 of the Policy and Procedures Manual.

c. Consumer funds shall not be loaned to other consumers, state employees, or any other agency or person. Nor shall the consumer accept any loan from other consumers, state employees or any other agency or person.

d. Consumer funds may be used to pay for the extraordinary expenses of an escort/attendant when the consumer is traveling, on vacation or participating in community activities. These expenses may include the cost of transportation, admission fees, meals and/or lodging, but not souvenirs or other personal purchases for the escort/attendant.

   Recommendations from the Individual Spending Plan along with estimated expenses and availability of funds shall be submitted to the District Program Administrator/Manager for approval.

   Consumer funds that are advanced shall be reconciled against receipts for all expenditures. Any personal expenditure beyond the original funds that were advanced that are over $5.00 must be evidenced by an original receipt to be eligible for reimbursement.

   State employees cannot volunteer to be an escort/attendant when that activity is part of their job description.

Exceptions to part "d" require approval in the Planning Documents (Individual Support Plan/Person Centered Plan) and by the District Program Manager/Administrator.

e. The Individual Spending Plan (ISP) is developed as part of, and during, the consumer's Individual Support Plan/Person Centered Plan meeting. It is to include the fiscal planning for the consumer, what items are to be purchased, monthly expenditures, projected needs, current income, billing by the Division for residential services (room and board), etc., and is to be acknowledged and signed by those present.

During this fiscal planning the support coordinator shall inform the representative payee of his/her obligation to report to the Division the amount of benefits they receive and any changes in these benefits. They are also to be informed that the Division will bill up to 70% of the benefits to be used to offset a portion of the consumer's residential costs. It is especially important that the representative payee be informed that if he/she receives a large, lump sum payment from the benefit source, that they are to notify the Division, as the Division is required by Administrative Rule R6-6-1204.to bill a portion of those funds. (http://www.azsos.gov/public_services/Title_06/6-06.htm)

f. Unless allowed by law, consumer funds, including interest earnings, will not be used to defray the cost of administration, supplies, equipment, or services. However, bank and investment institution service charges for administering pooled checking and investment accounts may be offset against interest earnings.

g. Consumer funds can only be used for expenditures authorized in the Individual Spending Plan, except upon written approval of the District Program Administrator/Manager or designee.

If the ISP recommends that the consumer be issued a Debit Card, these recommendations from the ISP for the use of a Debit Card along with the plan on oversight and accounting of the use of the debit card shall be submitted for approval to the District

Business Operations Manager and then to the District Program Administrator/Manager for final approval.

The use of a credit card shall not be approved.

The purchase of gift cards shall not be approved. The use of gift cards does not allow for the level of accountability required by the Social Security Administration or the Division.

h. Unexpended consumer funds that have been advanced to a third party for purchases or allowances will be re-deposited in the bank and credited to the appropriate consumer's account. However, unexpended funds of less than $5.00 may be retained, provided they are expended for the consumer's incidental needs.

i. Funds belonging to consumers no longer requiring financial management from the Division shall be disposed of as noted in section 1315.

j. If the consumer is a child receiving Foster Care Services (Child Developmental Home), the Office of Accounts Receivable and Collections maintains his or her account, including dedicated accounts as required by the Social Security Administration.

k. Individual accounts may be established in the District Consumer Fund System to receive and distribute monthly personal spending allowances for consumers in Foster Care.

1313 Reviewing Consumer's Accounts

a. The District Consumer Funds Managers or designee shall conduct random reviews of individual consumer accounts

b. The service provider shall make an up-to-date ledger sheet available for review quarterly or upon request by the Support Coordinator as required in 1309.1b.

c. A balance sheet shall be sent to the assigned Support Coordinator monthly.

d. The Support Coordinator shall be notified when the individual's account exceeds $1,500 and also when it exceeds $2,000. The Support Coordinator shall make

every effort to assure that eligibility for Social Security benefits and Title XIX are maintained.

e. When the State *is not* the Representative Payee: the Division does not have the authority to require the representative payee to inform the Division of the balances in consumer's accounts.

The exception to this is when the consumer and/or representative payee is applying for Community Living Service funds, Client Services Trust Funds or other financial assistance, or eligibility for services.

When the Support Coordinator becomes aware that a consumer's account exceeds the maximum amount to maintain eligibility for Arizona Health Care Cost Containment System (AHCCCS) and/or Social Security benefits and the Division is ***not*** the representative payee, the Support Coordinator shall ensure that this is noted at the time of the Planning Meeting (Individual Support Plan/Person Centered Plan meeting) and that it is documented in the Spending Plan.

The support coordinator shall remind/notify the representative payee that anytime the consumer's funds/resources meet or exceed $2,000, as described by the Social Security Administration (SSA) for eligibility determination that they are to notify the SSA and AHCCCS.

This notification by the representative payee is required to be made within 30 days of the consumer's funds/resources meeting or exceeding the $2,000 limit. An immediate spend-down plan shall then be developed with the representative payee in accordance with the SSA's definition of the proper use of these benefits.

The Support Coordinator shall work with the representative payee to develop a spend down plan where the Division will bill the consumer's account at a higher rate until it goes below the eligibility limits for benefits and services . See part "f" below for 100 % bill down procedures.

f. When the State *is* Representative payee: when a consumer account exceeds the maximum to maintain eligibility for Arizona Health Care Cost Containment System (AHCCCS) and/or Social Security benefits, the Support Coordinator and the consumer team will develop a reasonable spend-down plan to bring the account below the current $2,000 limit.

1314 Changes in a Consumer's Status

a. If the consumer experiences any change in status, the Division of Developmental Disabilities District Consumer Funds Unit/staff must be notified. If the consumer is a social security beneficiary, the Social Security Administration must also be notified. This notification is to be done by the Support Coordinator or designee. These changes include the following:

1. The consumer dies;
2. The consumer moves;
3. The consumer marries;
4. The consumer starts or stops working, even if the earnings are small;
5. A consumer's condition improves;
6. The consumer starts receiving another government benefit or the amount of that benefit changes;
7. The consumer plans to leave the U.S. for 30 days or more;
8. The consumer is imprisoned for a crime that carries a sentence of over one month;
9. The consumer is committed to an institution by court order for a crime committed because of mental impairment;
10. Custody of a child changes or a child is adopted;

11. The consumer is a child (including a stepchild), and the parents divorce;

12. You can no longer be payee; or

13. The consumer no longer needs a payee.

Additional events that you must report for Supplemental Security Income (SSI) beneficiaries:

14. The consumer moves to or from a hospital, nursing home, or other institution;

15. A married consumer separates from his or her spouse, or they begin living together after a separation;

16. Somebody moves into or out of the consumer's household;

17. The consumer has any change in income or resources (i.e., a child's SSI benefit check may change if there are any changes in the family income or resources); or

18. The consumer has resources that exceed $2000.

b. The Support Coordinator will report any changes in the residential settings where room and board is paid to the provider, including both permanent or temporary placement changes. These reports are to be sent to Central Office, Site 791A Residential Billing, on the Division of Developmental Disabilities (DDD) Billing and Benefit Information form.

These will then be forwarded to the Division of Business and Finance - Office of Accounts Receivable and Collections. A copy is to be placed in the consumer's file and a copy sent to the District Consumer Funds Manager. A Division of Developmental Disabilities (DDD) *Billing and Benefit Information form* is required on all new placements and changes to all out-of-home placements within five (5) working days of placement.

c. A Division of Developmental Disabilities (DDD) *Billing and Benefit Information form*, is also required for all the following:

1. consumer leaves care

2. consumer moves out-of-state

3. consumer transfers to another District

4. there is a change in billing information

5. consumer dies

6. there is a change representative payee

7. there is a request for a billing waiver

8. there is change in income (earned or unearned)

9. consumer has a change of address

10. consumer enters/leaves acute care facility

1315 Investing Consumer funds

Interest earnings, minus any bank charges on Consumer funds that are invested in the State Treasurer's Office, will be apportioned to consumer's accounts quarterly based on account period ending balances.

1316 Termination of a Consumer's Account or Change in Representative Payee

Generally, a consumer's account is made up of Social Security benefits, earned money, family gifts, and other payments. Social Security benefits make up the largest percentage of these accounts; therefore all applicable Social Security laws and rules are applied first to terminate a consumer account. These are outlined in the Social Security publication: "Understanding the Benefits", Pub. No. 10024. (www.ssa.gov/pubs).

Fund balances will be returned to the consumer, Social Security Administration, guardian, or other authorized entity by check. But

this will only be done after all outstanding debts are paid including residential billing in accordance with appropriate rule and law regarding terminated accounts statements. See Policy and Procedures Manual, Chapter 1100 – Case Closure.

a. When a consumer dies and there is no entity to receive money from the consumer's account and there is no family, guardian, custodian, executor or beneficiary, the following Arizona Revised Statutes will apply in the disbursement of the account: A.R.S. § 44-312, § 44-313, § 44-317, §12-881, and §12-887. www.azleg.gov.

b. Funds not attributed to Social Security benefits as identified on parts 3 and 4 of this section and not able to be assigned to a family member, estate, guardian, custodian, executor or beneficiary, will be paid to the Arizona Department of Revenue, Unclaimed Property Unit. (See their publication #601 for details (www.azunclaimed.gov).

1. Funds of deceased individuals may be used to pay for funeral expenses and shall be used for other outstanding debts, including residential room and board costs, before closing the account.

2. Accounts having been determined to be inactive (having no transactions for a year or more) will be terminated after reasonable efforts to dispense funds have failed. The account will be closed and funds sent to the Arizona State Treasurer after five (5) years. (Unclaimed Property – Arizona Department of Revenue, Unclaimed Property Unit.)

3. **Social Security (SSA, Title II)** is paid after the month of eligibility. Any funds received from the Social Security Administration the month after the death of a consumer receiving SSA, shall not be spent, but shall be returned to the Social Security Administration.

For example, – If the consumer dies on May 30th the last day of the month and the SSA check received the first of May was for April the

check is due and payable as the consumer was alive and eligible for the **entire** month of April.

However, if a check is received the first of June for May, The Support Coordinator or designee shall return the check as the consumer was not eligible for SSA for the **entire** month of May, the month the consumer died.

4**.** **Supplemental Security Income (SSI)** is paid in anticipation of eligibility. Any funds received from the Social Security Administration during the month of the consumer's death remain the property of the consumer's estate. Funds received the month after a consumer's death shall not be spent, but shall be returned to the Social Security Administration.

For example, if a SSI check comes May 1, and the consumer was alive during some portion of May, the check is due and payable. If a Check comes in June, the Support Coordinator or designee shall return it as the consumer was not alive or eligible in June.

For additional information regarding SSI resources, refer to – Pub No. 05-10029 - Disability Benefits and 05-11011 – "What You Need to Know When You Get SSI Benefits" (www.ssa.gov/pubs).

To report changes to the Social Security Administration, call or visit your local Social Security office. The Support Coordinator or designee shall document the phone call in the case record including information on who they talked with, the date and the outcome.

To report changes to the Division, contact your local District Consumer funds Unit/staff.

c. When a change in representative payee is made from the Division to another entity, after all debts incurred while the Division was Representative Payee are paid, all of the Consumer Funds that can be identified

as Social Security Benefits are to be returned to the Social Security Administration. The new representative payee is then to request these funds from the Social Security Administration. They are not to be transferred directly from the Division to the new representative payee. Providers shall not be representative payees for consumers. Also, agency board members are prohibited from being representative payees except for members of their own families who are consumers.

d. If the new representative payee is NOT the Division, any funds remaining in the "Consumer's Personal Allowance Fund" that were generated as a foster child shall be sent back to the Social Security Administration. The Social Security Administration may then transfer these funds to the new representative payee.

If the Division becomes the new representative payee, these funds are transferred to the new account that is set up in the local District Business Office for the consumer's personal use.

e. A person willing to become the representative payee must file a Social Security Administration form (www.ssa.gov/about.htm) requesting a change in payee.

If no one else is available, the Division may request to become the representative payee. Or Social Security may request/require the Division to become the representative payee. A Consumer Fund System account is set up in the local district Business Office.

The Social Security Administration is to be notified of the change of address to the local Business Office for the District.

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1600 MANAGING INAPPROPRIATE BEHAVIORS

1601 Overview

This chapter outlines requirements for developing and implementing effective strategies that address behavioral intervention and management of specific individual behavior considered to be inappropriate. In this context, inappropriate means to significantly interfere with, prevent or deny individual opportunities for community integration and full inclusion; to be at risk to an individual's own health and safety and/or, to be at risk to the health and safety of others.

In this chapter are definitions, applicability, emergency measures, and the programmatic functions and responsibilities of the Individual Support Plan/Individual Family Support Plan/Person Centered Plan (ISP/IFSP/PCP) teams (Planning Teams), training, Human Rights Committees (HRC), and Program Review Committees (PRC), Also included are HRC's prohibitions related to behavioral programming, abuse, and neglect, behavior interventions and treatment plans.

1602 Definition and Applicability

Arizona Administrative Code (A.A.C.) R6-6-901, is titled *Managing Inappropriate Behavior*. Commonly referred to as Article 9, it governs the Division of Developmental Disabilities' (Division) administration of a comprehensive statewide system for behavioral interventions, and establishes the structure for developing, approving, implementing and monitoring these plans.

All programs operated, licensed, certified, supervised or financially supported by the Division must comply with these policies and procedures. If a need to reduce inappropriate behaviors is identified, the Planning Team must determine whether a behavior treatment plan is needed. Behavior treatment plans, which include any of the interventions outlined in Section 1606.1, must be approved by the PRC and reviewed by the HRC.

A.R.S. § 36-551
azleg.gov/ArizonaRevisedStatutes.asp

A.A.C. R6-6-901
http://www.azsos.gov/public_services/rules.htm

1603 Prohibitions

State statute prohibits abusive treatment or neglect of any individual with a developmental disability.

1603.1 Abuse

Prohibited abusive treatment, as it relates to managing inappropriate behavior, includes programmatic abuse, which uses an aversive stimuli technique that has not been approved as part of an individual's ISP, and which is not contained in the rules and regulations. This includes individual isolation.

Reference Chapter 2000 for more detailed information on abuse.

A.R.S. § 36-569(A); § 36-561(B)
azleg.gov/ArizonaRevisedStatutes.asp

A.A.C. R6-6-9
http://www.azsos.gov/public_services/rules.htm

1603.2 Neglect

Neglect of an individual with a disability is prohibited. Neglectful treatment means any intentional failure to carry out a behavior treatment plan developed for an individual by the Planning Team.

Chapter 2000 contains more detailed information regarding neglect.

A.R.S. § 36-569; § 36-561
azleg.gov/ArizonaRevisedStatutes.asp

A.A.C. R6-6-902
http://www.azsos.gov/public_services/rules.htm

1603.3 Behavioral Intervention Techniques

Identified below are those techniques which are prohibited under the provisions of Article 9:

A. Use of locked time-out rooms.

B. Use of over-correction. This means a group of procedures designed to reduce inappropriate behavior, consisting of:

1. requiring an individual to restore the environment to a state vastly improved from that which existed prior to the inappropriate behavior; or

2. requiring an individual to repeatedly practice a behavior.

C. Application of noxious stimuli such as ammonia sprays, or Tabasco sauce to the tongue.

D. Physical restraints, including mechanical restraints, when used as a negative consequence to a behavior;

E. Any other technique determined by the PRC to cause pain, severe discomfort, or severe emotional distress to the individual.

F. Techniques addressed in A.R.S. § 36-561(A):

1. Psychosurgery.

2. Insulin shock.

3. Electroshock.

4. Experimental drugs.

A.R.S. § 36-561; § 36-551(A)
azleg.gov/ArizonaRevisedStatutes.asp

A.A.C. R6-6-902
http://www.azsos.gov/public_services/rules.htm

1603.4 Behavior Modifying Medications

A. Except as indicated and specified in statute and rule, behavior modifying medications are prohibited if any one of the following criteria are met:

B. They are administered on an as-needed or PRN basis.

C. The Planning Team determines that the dosage interferes with the individual's daily living activities.

D. They are used in the absence of a behavior treatment plan.

Section 1607 of this chapter contains broader information regarding Behavior Modifying Medications.

A.R.S. § 36-561
azleg.gov/ArizonaRevisedStatutes.asp

A.A.C. R6-6-902
http://www.azsos.gov/public_services/rules.htm

1603.5 Behavior Treatment Plan Implementation

No one shall implement a behavior treatment plan that:

A. Is not included as part of the ISP.

B. Contains aversive behavior intervention techniques which do not have approval of the PRC and review by HRC.

A.R.S. § 36-561; § 36-569
azleg.gov/ArizonaRevisedStatutes.asp

A.A.C. R6-6-903(A)
http://www.azsos.gov/public_services/rules.htm

1604 Violations

Any person violating the statutory provisions regarding the health and safety of persons with developmental disabilities is guilty of a class 2 misdemeanor.

A.R.S. § 36-569; § 36-561
azleg.gov/ArizonaRevisedStatutes.asp

1605 Program Review Committee

The Program Review Committee (PRC) is an assembly designated by the District Program Manger that reviews any behavior treatment plan that meets the criteria set forth in Section 1606.1. The PRC approves plans, or makes recommendations for changes as necessary.

42 CFR 483.440(f)(3)
http://www.gpoaccess.gov/uscode/index.html

A.A.C. R6-6-903; R6-6-1701, et seq.
http://www.azsos.gov/public_services/rules.htm

1605.1 Composition

The District Program Manager (DPM) is responsible for designating persons to serve on the PRC. At a minimum, the team should include:

A. The DPM or designee as the chairperson.

B. A person directly providing habilitation services.

C. A person determined by the Division as qualified in the use of behavior management techniques, such as a psychologist or psychiatrist.

D. The parent/guardian of a person with a developmental disability, but not the parent of the person whose program is being reviewed.

E. Persons with no ownership/controlling interest in a facility, and no involvement in service provision to persons with developmental disabilities.

F. A person with a developmental disability when appropriate.

A.A.C. R6-6-903(E)
http://www.azsos.gov/public_services/rules.htm

1605.2 Responsibilities

The PRC must review and respond in writing within 10 working days of the receipt of a behavior treatment plan. The written response must be signed and dated by each member in attendance, forwarded to the Planning Team and a copy sent to the chairperson of the HRC. The written response shall include:

A. A statement of agreement that the interventions approved are the least intrusive, and that they are the least restrictive alternative.

B. Any special considerations/concerns, including specific monitoring instructions.

C. Any recommendations for change, with explanations.

The PRC shall issue written reports to the DDD Assistant Director, summarizing its activities, findings/recommendations while maintaining the individual's confidentiality. Reports are required:

A. Monthly to the designated Division staff, with a copy to the chairperson of the HRC.

B. Annually, by December 31 of each calendar year, to the DDD Assistant Director or designee, with a copy sent to the Developmental Disabilities Advisory Council.

A.A.C. R6-6-903
http://www.azsos.gov/public_services/rules.htm

1606 Individual Support Plan Team

1606.1 Responsibilities

The Planning Team must submit to the PRC and HRC any behavior treatment plan that includes:

A. Techniques that require the use of force.

B. Programs involving the use of response cost. This means a procedure often associated with token economies, designed to decrease inappropriate behaviors, in which reinforcers are taken away as a consequence of inappropriate behavior.

C. Programs that might infringe upon the rights of the individual.

D. The use of behavior modifying medications.

E. Protective devices used to prevent an individual from self-injurious behavior.

Upon receipt of the PRC's response, and as part of the plan development process, the Planning Team must either:

A. Implement the approved behavior treatment plan.

B. Accept the PRC recommendation, and incorporate the revised behavior treatment plan into the ISP.

C. Reject the PRC recommendation and develop a new behavior treatment plan.

All revised behavior treatment plans must be re-submitted to the PRC and the HRC for review and approval. No implementation shall occur prior to approval.

1606.2 Restitution

Restitution:

A. Means the act of paying or compensating for property loss or damage.

B. Does not include voluntary compensation by a parent or guardian.

C. May not infringe on an individual's rights protected by A.R.S. § 36-551.

Providers are required to have insurance to cover property loss or damage. If a member damages the property of another, the injured party may have a legal remedy in the small claims division of the Justice Courts.

The Division and its contracted providers cannot make restitution a condition for provision of services or supports. A member's behaviors cannot prevent that member from receiving services through the Division. Behaviors that result in property damage or loss should be addressed by the Planning Team.

1607 Behavior Modifying Medications

Behavior modifying medications are drugs prescribed, administered and directed specifically toward the reduction and eventual elimination of specific behaviors, including herbal remedies due to their psychoactive and potentially behavior modifying properties.

Behavior modifying medications are only to be prescribed and used:

A. As part of the individual's behavior treatment plan included in the ISP.

B. When in the opinion of a licensed physician, they are deemed to be effective in producing an increase in appropriate behaviors or a decrease in inappropriate behaviors.

C. When it can be justified by the prescribing physician that the harmful effects of the behavior clearly outweigh the potential negative effects of the medication. Two examples of when the risks and benefits of the medications need to be reviewed with individuals with developmental disabilities, their families and/or their guardians.

1. The older antipsychotic medications such as Thorazine (chlorpromazine), Mellaril (thioridazine), Haldol (haloperidol) and Navane (thiothixene) may cause such as *tardive dyskinesia*, a permanent muscular side effect. Tardive dyskinesia is characterized by slow rhythmic, automatic movements, either generalized or in single muscle groups.

2. The new antipsychotic medications such as Risperdal (risperidone), Zyprexa (olanzapine), Seroquel (quietapine), Abilify (aripiprazole) and Geodon (ziprasidone) are much less likely to cause tardive dyskinesia. However, these medications carry a high risk of significant weight gain. One study found 18 pounds average weight gain in three months.

   Such significant weight gain can result in the development of a metabolic syndrome, which is defined as three or more of the following:

   i. Increased waist circumference.

   ii. Elevated triglycerides.

   iii. Reduced HDL (good) cholesterol.

   iv. Elevated blood pressure.

   v. Elevated fasting glucose.

   These factors lead to a much higher risk of heart disease and diabetes.

The use of behavior modifying medications requires the Division to make available the services of a consulting psychiatrist to review medical records and make recommendations to the prescribing physician, which ensures the prescribed medication is the most appropriate in type/dosage to meet the needs of the individual.

The Division must provide monitoring of all behavior treatment plans that include the use of behavior modifying medications to:

A. Ensure that data collected regarding an individual's response to the medication is evaluated at least quarterly at a medication review by the physician and a member of the ISP

team, other than the direct care staff responsible for implementing the approved behavior treatment plan.

B. Ensure that each individual receiving a behavior modifying medication is screened for side effects and tardive dyskinesia as needed, and that the results of such screening are:

1. documented in the individual's central case record;

2. provided immediately to the physician, individual/responsible person and ISP team for appropriate action in the event of positive screening results for side effects/tardive dyskinesia; and

3. provided to the PRC and HRC, and the Division's Medical Director within 15 working days for review of the positive screening results.

The individual/responsible person must give informed, written consent before behavior modifying medications can be administered. Non-scheduled or as-needed sleep preparations are not allowed, whether prescribed or over-the-counter. Aromatherapy does not require a behavior treatment plan, but must be done with the consent of the individual or his/her legal guardian.

See Chapter 1500 for more detailed information regarding informed consent and the related forms.

A.A.C. R6-6-905; R6-6-908; R6-6-909
http://www.azsos.gov/public_services/rules.htm

1608 Monitoring Behavior Modifying Medications/Treatment Plans

For all behavior treatment plans that include the use of behavior modifying medications, the Division must:

A. Provide second level reviews by a consulting psychiatrist to provide recommendations to the prescribing physician that ensure that the prescribed medication is the most appropriate in type and dosage to meet the individual's needs.

B. Ensure that data collected regarding an individual's response to the medication is evaluated at least quarterly by the physician and the member of the ISP Planning Team designated pursuant to A.A.C. R6-6-905, and other members of the ISP team as needed;

C. ensure that each individual receiving a behavior modifying medication is screened for side effects, and tardive dyskinesia as needed, and that the results of such screening are:

1. documented in the individual's case record;

2. provided immediately to the physician, individual, responsible person, and ISP team for appropriate action in the event of positive screening results; and

3. provided to the PRC and HRC within 15 working days for review of positive screening results.

In the event of an emergency, a physician's order for a behavior modifying medication may, if appropriate, be requested for a specific one time emergency use. The person administering the medication shall immediately report it to the Support Coordinator, the responsible person and any applicable Division designee. The responsible person shall immediately be notified of any changes in medication type or dosage.

A.A.C. R6-6-905; R6-6-908(B); R6-6-909
http://www.azsos.gov/public_services/rules.htm

1608.1 Paper Reviews

The following guidelines have been designed to provide an option to both the Planning Team and the PRC to meet minimum requirements for annual review of an established behavior treatment plan through a paper review process. This option is limited solely to situations where the individual is on psychotropic medications, and during the annual review by the PRC the presented information and data clearly demonstrate that the individual's behavior has been stable for one year.

Applicability

Paper reviews are considered appropriate when the individual's behavior treatment plan involves the use of psychotropic medications, including the use of over-the-counter and herbal medications when used to modify behavior, but does not involve the utilization of more restrictive approaches and/or strategies.

Note: The use of psychotropic medications is prohibited if they are administered on an as-needed, or PRN, basis, they are in dosages which interfere with the individual's daily living activities (as

determined by the Planning Team), or they are used in the absence of a behavior treatment plan.

If the individual's behavior treatment plan includes any of the following techniques and/or strategies, the plan is not eligible for the PRC's paper review process:

A. Techniques that require the use of force.

B. Programs involving the use of response cost.

C. Programs that might infringe upon the rights of the consumers pursuant to applicable federal and state laws, including A.R.S. § 36-551.01.

D. Protective devices used to prevent a person from sustaining injury as a result of the person's self-injurious behavior.

For consumers living in an Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID), federal rules and regulations will take precedence over these guidelines for paper review.

Eligibility

An individual's behavior treatment plan may be monitored by the PRC's annual paper review process, if the following criteria are met:

A. The individual participated in his/her program, activities of daily living and chosen leisure/community activities without any significant behavioral disturbances for the previous 12 months.

   Significant behavioral disturbance is defined as any physical aggression, or pattern of verbal aggression or other actions that are not typical for the individual (such as significant deterioration in personal hygiene or social withdrawal).

B. There were no behavioral incidents requiring the use of emergency measures during the previous 12 months.

   Emergency measures are defined as the use of physical management techniques or psychotropic medications in an emergency to manage a sudden, intense or out-of-control behavior.

C. During the previous 12 months, there were no changes in the individual's prescribed psychotropic medications.

The exception to this criterion is if the individual required an increase in an antidepressant medication and it was in the absence of any behavioral disturbances.

D. Through a review of all incident or serious incident reports for the individual during the previous 12 months, there were no situations noted where the individual's behavior resulted in police involvement, psychiatric hospitalization, or crisis intervention through the behavioral health system.

Initial Consideration of Paper Reviews

For the PRC to consider annual reviews using the paper review process, the Planning Team must provide the following:

A. A copy of the individual's current Planning Document.

B. A copy of the individual's current behavior treatment plan, with data and information that meets the criteria set forth in the "Eligibility" section above.

C. Documentation that there is on-going medical monitoring, quarterly medication reviews, and laboratory testing as needed.

D. Copies of the *Support Coordinator's Review of the ISP/IFSP/PCP (DD-500)* for the previous 12 months.

Subsequent Annual Paper Reviews

For the PRC to complete subsequent paper reviews of an individual's behavior treatment plan, the Planning Team must provide at a minimum:

A. A copy of the individual's current ISP/IFSP/PCP.

B. A copy of the individual's current behavior treatment plan, with information or data indicating the individual's continuous stable behavior.

C. Copies of on-going medical monitoring reports, quarterly medication reviews and any required laboratory testing, for the previous 12 months.

D. Copies of the *Support Coordinator's Review of the ISP/IFSP/PCP (DD-500)* for the previous 12 months.

E. Any other information requested by the PRC.

Responsibilities of the PRC

Upon receipt from the Planning Team of the required information detailed in the sections above, the PRC chairperson will:

A. Schedule a review of the submitted information by the entire membership of the PRC.

B. Request further information, and/or schedule a face-to-face review if during the paper review process it is determined that further information is needed.

C. Forward a disposition report to the Planning Team. The disposition report will indicate approval, any recommendations made and the date of the next scheduled review.

Loss of Eligibility for Paper Review

If any of the following situations occur, the Planning Team must notify the PRC chairperson in writing within 30 days of the occurrence. The Planning Team must also reconvene and, if the behavior treatment plan was amended, forward a copy to the PRC within 90 days. This includes situations where:

A. The individual cannot participate in his/her program, activities of daily living and/or leisure activities of his/her choice, due to any significant behavioral disturbance.

B. An emergency measure intervention was utilized (physical and/or chemical restraint).

C. Any change or increase in the individual's psychotropic medications was made.

D. Note: The only exception to this criterion is if the individual required an increase in an antidepressant medication and it is in the absence of any behavioral disturbances

E. The individual's negative behavior results in law enforcement involvement, psychiatric hospitalization, crisis intervention by the behavioral health system, or injury to oneself or others.

Upon receipt of the individual's behavior treatment plan from the Planning Team, the PRC will schedule a formal review of the plan. Subsequent PRC reviews of the behavior treatment plan will be conducted face-to face until the individual has been stable on his/her psychotropic medications for one year.

1608.2 Exit Criteria

For an individual's behavior treatment plan to exit from the PRC's required annual review the following criteria must be met:

A. Discontinuation of psychotropic medications as part of the behavior treatment plan strategy.

B. Psychotropic medication is clearly prescribed for a non-behavior modifying purpose.

1. Rationale for the medication is clearly documented by the prescribing physician as being medical in nature (i.e., migraine, seizures, etc.), with no associated behavioral disturbance or issues.

2. The PRC must be satisfied that use of the psychotropic medication will continue to be monitored by the prescribing physician and that there is clearly not a need for a behavior treatment plan to be developed by the Planning Team.

3. Unless otherwise indicated, use of a psychotropic medication prescribed for a non-behavior modifying reason and without the need for a formal behavior treatment plan will only require a one-time review and approval by the PRC.

C. Elimination of the use of other more restrictive approaches/strategies within the behavior treatment plan that require PRC review and approval and/or annual review, per R6-6-903.A:

1. Techniques that require the use of force.

2. Programs involving the use of response cost.

3. Programs which might infringe upon the rights of the individual pursuant to applicable federal and state laws, including A.R.S. § 36-551.01.

4. Protective devices used to prevent an individual from self-injurious behavior.

D. The individual is discharged from services through the Division.

For individuals living in an Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID), federal rules and regulations will take precedence over the exit criteria outlined above.

1609 Emergency Measures

When an emergency measure, including the use of behavior modifying medications is employed to manage a sudden, intense, and out-of-control behavior, the person employing the measure must:

A. Report the circumstances immediately to the person designated by the Division, the responsible person and the Support Coordinator (see Chapter 2100);

B. Provide a written report of the circumstances of the emergency measure to the responsible person, the Support Coordinator, and the PRC and HRC chairpersons within one day.

C. Request that the Support Coordinator reconvene the Planning Team to determine the need for a new or revised behavior treatment plan when any emergency measure is used two or more times within a 30-day period or with an identifiable pattern.

The Support Coordinator is responsible for documenting in the individual's case record the outcome of the Planning Team.

Upon receipt of a written report as specified above, the PRC must:

A. Review, evaluate and track reports of emergency measures taken.

B. Report, on a case-by-case basis, instances of excessive or inappropriate use of emergency measures for corrective action, to a person designated by the Division.

A.A.C. R6-6-909(D)
http://www.azsos.gov/public_services/rules.htm

1610 Physical Management Techniques

Client Intervention Training (CIT) establishes specific techniques to be employed by staff and providers during an emergency to manage a sudden, intense and out-of-control behavior. These techniques can only be used by persons certified in CIT. Such physical management techniques must:

A. Use the least amount of intervention necessary to safely manage an individual.

B. Be used only when less restrictive methods were unsuccessful or are inappropriate.

C. Be used only when necessary to prevent the individual from harming himself/herself or others, or causing severe property damage.

D. Be used concurrently with the uncontrolled behavior.

E. Be continued for the least amount of time necessary to bring the individual's behavior under control.

F. Be appropriate to the situation to ensure safety.

Persons may be re-certified in CIT if their supervisor determines that there is a need for re-training. This re-training can be accomplished by:

A. Viewing a videotape of the techniques, passing a written test and demonstrating the techniques to the satisfaction of an instructor, or

B. Attending the entire CIT course again.

A.A.C. R6-6-906; R6-6-908; R6-6-909
http://www.azsos.gov/public_services/rules.htm

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1700 SAFETY

1701 Fire Safety

This section outlines the fire safety requirements for community residential settings which are operated or supported by DES/DDD.

1701.1 Fire Risk Profile

A Fire Risk Profile (FRP, DD-364, Appendix 1700.A) shall be completed for each community residential setting serving four (4) or more individuals. The FRP is a DES/DDD instrument that yields a score for a facility based on the ability of individuals to evacuate the community residential setting. The Fire Risk Profile should be updated when an individual enters or exits the residential program and when the needs of an individual in one or more of the seven categories outlined below changes significantly. The FRP should also be updated each time there is a structural change in the home. The FRP is required to be updated at least annually even if changes do not occur in the composition or structure of the setting. The FRP will be routinely reviewed for accuracy by DES/DDD; if concerns are identified, the issue will be referred to the Individual Support Plan (ISP) Team for resolution.

1701.1.1 Completion Instructions for the FRP

The name of each individual should be listed in the designated section of the FRP. Each individual should be evaluated on the seven (7) factors identified on the FRP, using the rating that best describes the individual. Place the appropriate ratings values in columns to the right. Add the values for each individual to determine the sum of his/her rating. If an individual's rating exceeds 100, use only 100. To determine the facility rating, add together the ratings of all individuals.

The following guidelines should be used in evaluating each individual's abilities and needs for the seven factors on the FRP:

a. social adaptation - This factor rates the individual's willingness to assist others and to cooperate in the evacuation process.

   1. Positive - the individual is generally willing to assist others as far as (s)he is able and can participate in a

nonspecific "buddy system" - helping or alerting anyone close to him/her in a fire emergency who needs assistance to evacuate. The individual's physical ability to help should not be considered for this item because it will be addressed under other factors. (Rating of 0)

2. None - the individual does not usually interact with other individuals in everyday situations and, therefore, could not be expected to assist or alert others in a fire emergency. (Rating of 8)

3. Negative - the individual does not interact well with other individuals and exhibits frequent disruptive behavior. (S)he is likely to be uncooperative. (Rating of 16)

b. Mobility - This factor rates the individual's physical ability to initiate and complete an evacuation.

1. Within Normal Range - the individual is physically able to initiate and complete an evacuation. (Rating of 0)

2. Speed Impairment/Needs Some Assistance - the individual may require some initial staff assistance, e.g., getting out of bed, getting into a wheelchair, but can continue an evacuation without further assistance. (Rating of 50)

3. Needs Full Assistance - the individual may require the full attention of staff member throughout the evacuation. (Rating of 100)

c. Response to Instructions - This factor concerns the extent to which an individual can receive, comprehend and follow through with simple instructions from staff. Evaluate the amount of guidance required to be reasonably certain that individuals will follow through with instructions given during an evacuation. Consider only the individual's normal abilities to follow instructions; behavior under stress and sensory impairment are rated as separate factors.

1. Follows Verbal Instructions - the individual will reliably comprehend, remember and follow simple, brief instructions stated verbally or in sign language. (Rating of 0)

2. Requires Physical Guidance - the individual cannot be depended on to understand and follow directions, therefore, the individual may need to be guided,

reminded, reassured or otherwise accompanied during the evacuation, but will not require the exclusive attention of a staff member. (Rating of 12)

3. Does Not Respond to Instructions - the individual may not respond to instructions or general guidance. The individual may require considerable assistance and most of the attention of a staff during the evacuation. (Rating of 24)

d. Behavior Under Stress - This factor concerns the individual's ability to cope with the stress of an emergency.

1. No Significant Change - the individual will probably experience a level of stress that will not markedly interfere with his or her ability to evacuate. (Rating of 0)

2. Degraded Reaction - the individual may react to a fire emergency with confusion, slowed reaction, poor adaptability to hazards or a partial (focal) or petit mal seizure that disables the individual for no more than 30 seconds. (Rating of 8)

3. Significant Risk - the individual may react to a fire emergency with physical or passive resistance to evacuation or a grand mal, severe generalized or other seizure that disables the individual for longer than 30 seconds. (Rating of 16)

e. Fire Awareness - This factor concerns the individual's ability to appropriately respond to fire related cues. Fire related cues include smoke, flames, fire alarms and warnings from others. Evaluate how well the individual is likely to perform in response to such cues, assuming that no one may be available to give them instructions at the time of the emergency.

1. Will Evacuate When Fire Signs are Present or Alarm Sounds - the individual will probably initiate and complete an evacuation in response to signs of an actual fire, warnings from other individuals or a fire alarm. Also, the individual can be depended on to avoid the hazards of a real fire such as flames and heavy smoke. (Rating of 0)

2. Responds to Fire Signs/Alarms but Needs Assistance to Avoid Hazard - the individual will probably respond to an actual fire, warnings from other individuals or a fire alarm, however, the individual may not satisfactorily avoid the hazards of

a fire or cannot be relied on to complete the evacuation without assistance. (Rating of 8)

3. No Fire Awareness/Needs Assistance - the individual does not respond to signs of an actual fire, warnings from staff or other individuals or a fire alarm. The individual should be closely attended by staff member during an emergency evacuation. (Rating of 16)

f. Sensory Impairment - This factor evaluates any sensory impairment which, without adaptations, limits the individual's ability to evacuate.

1. Within Normal Limits/Needs No Assistance - the individual may have a severe hearing or sight loss but would need no assistance in case of fire evacuation. Placing someone in this category might require a consideration of special features in the home such as a strobe light and bed vibrator alerting systems. With these systems, a hearing impaired individual might qualify for this category. (Rating of 0)

2. Impairment/Assistance Needed to Start Evacuation - the individual has severe hearing and/or sight loss and would need to be alerted to the presence of the fire emergency but, otherwise, could evacuate without assistance. (Rating of 10)

3. Impairment/Assistance Needed Throughout Evacuation - the individual has severe hearing and/or sight loss and would need guidance or other assistance in order to evacuate. (Rating of 20)

g. Medication - This factor rates the impact of any medication on an individual's ability to evacuate.

1. None - the individual does not take medication which can be expected to have an effect on the central nervous system for a chronic condition. (Rating of 0)

2. Maintenance Medication - the individual routinely takes medications which can have some effect on the central nervous system, i.e., seizure controlling, antihistamines, mild tranquilizers, stimulants, etc. The primary purpose of these medications is not to induce sleep. (Rating of 4)

3. Nocturnal Medication - the individual routinely takes medication for the primary purpose of inducing or maintaining sleep. (Rating of 8)

1701.2 Fire Safety Requirements

All community residential settings are directed to operate in compliance with Level I requirements. Settings with an FRP which exceeds 300 are directed to additionally operate in compliance with Level II requirements.

A.A.C. R6-6-701, et. seq

1701.2.1 Level I Fire Safety Requirements

At a minimum, all community residential settings shall meet the following:

a. the address of the setting is posted and clearly visible from the street; if posting is not possible, local emergency services have been notified of the location of the home;

b. smoke detectors are working and are appropriately placed in each of the following areas:

   1. bedrooms;

   2. rooms or hallways adjacent to bedrooms; and

   3. rooms or hallways adjacent to the kitchen.

c. a minimum of one 2A, 10B, C fire extinguisher is available in the home; the maximum travel distance to access a fire extinguisher is 75 feet, without having to pass through a locked passageway; all fire extinguishers have been serviced annually or as recommended by the manufacturer; all fire extinguishers are tagged specifying the date of purchase or the date of servicing, whichever is more recent, and the company performing the servicing work, if applicable;

d. all stairways, hallways, walkways and other routes of evacuation are free from obstacles that prohibit exit in case of emergency;

e. each sleeping room has at least one operable window or door that opens onto a street, alley, yard or exit court for emergency exit;

f. locks, bars, grilles, grates or similar devices installed on windows or doors which are used for emergency exit are equipped with release mechanisms which are operable from the inside without the use of a key or special knowledge or effort;

g. a floor plan of the setting is available which designates the routes of evacuation, location of fire fighting equipment and location of evacuation devices. (Note: The floor plan is not required to be posted unless the setting serves seven or more individuals. In this case, the floor plan must be posted on each floor and wing, if applicable.);

h. the setting has a working telephone;

i. emergency telephone numbers for fire, police and local emergency medical personnel, or 911, as appropriate for the local community, are in close proximity to all telephones in the setting;

j. electrical outlet plates are in good condition and cover the receptacle box;

k. combustible and/or flammable materials are not stored within (three) 3 feet of furnaces, heaters or water heaters;

l. as applicable, each operable fireplace in the setting is protected at all times by a fire screen or metal curtain; and

m. the premises does not have an accumulation of litter, rubbish or garbage that may be considered a fire hazard.

1701.2.2 <u>Level II Fire Safety Requirements</u>

At a minimum, all community residential settings with a FRP which exceeds 300 shall meet the following:

a. the setting is in full compliance with the Level I Fire Safety Standards;

b. the setting is equipped with back-up lighting designed to illuminate a path to safety in case of power failure;

c. unless the setting is equipped with a residential sprinkler system, two staff persons are on duty at all times;

d. the setting is equipped with an early warning fire detection system OR a residential fire sprinkler system:

1. an early warning fire detection system consists of smoke detectors in the sleeping and living areas and heat detectors in the high risk areas. These detectors are 110 volts with a battery back-up and wired so that all alarms sound when smoke is detected;

2. residential fire sprinkler systems are installed by a Licensed Contractor (Plumbing or Sprinkler Installer).

1701.3 Fire Inspection

All community residential settings are directed to pass an annual fire inspection by state or local fire authorities. The annual fire inspection should document the setting's full compliance with Level I and, as applicable, Level II Fire Safety Requirements.

Documentation of the completed fire inspection should be maintained in the community residential setting.

A.A.C. R6-6-714

1702 Vehicle and Equipment Safety (RESERVED)

1703 Communicable/Infections Diseases (RESERVED)

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1800 RECORDS MANAGEMENT

1801 Overview

This chapter describes the DES/DDD's responsibility for compliance with the rules, regulations, standards and procedures regarding the supervision and management of all recorded, personally identifiable information which is obtained during the application, provision of services and referral processes.

Information is presented on confidentiality, case record and documentation requirements and file storage and security.

1802 Confidentiality

Confidential Information

DES/DDD adheres to statutory, administrative rule, and Departmental requirements that all personally identifiable information obtained, and records prepared during the course of application and provision of services concerning any applicant, claimant, recipient, employer or member is to be considered confidential and privileged, unless otherwise provided by law.

This confidentiality includes members or persons involved in dependency actions, case closure of parental right actions or in any protective services action.

A.R.S. § 36-568(01); § 36-551(07); § 41-1959;
A.A.C. R6-6-102, et seq.

Confidentiality Officer

Each District Program Manager (DPM) must designate, in writing, a person as confidentiality officer and provide the name of the designee to the Assistant Director and District staff. The confidentiality officer shall completely administer and supervise the use of all personally identifiable information including storage, disclosure, retention, and destruction of this information in accordance with departmental procedures of the DES and the Department of Library, Archives and Public Records.

Confidentiality officers or their designee(s) must ensure that members/responsible persons are notified of their rights of confidentiality regarding the disclosure of personally identifiable information such as name, SSN, ASSISTS or AHCCCS I.D. This notification must occur at the time of eligibility closure and during subsequent Individual Support Plans (ISPs). Rights of confidentiality include:

A. the right to inspect/review their own records without unnecessary delay (within 45 days) with the understanding that they may not be denied access to such records;

B. the right to be informed of the procedures for inspecting, reviewing, and obtaining copies of their records;

C. the right to receive one copy of their medical record free of charge annually;

D. the right to be informed of a description of circumstances whereby, for legitimate cause, the agency may deny a request for copies of a case record, even though the record may be reviewed;

E. the right to a listing of types and locations of records maintained and the titles/addresses of the officials responsible for such records;

F. the right to a policy regarding written consent for release of information shall insure that personally identifiable information shall not be released outside the DES/DDD without the written and dated consent of the responsible person except as required by federal law, State statute, court order, or in the event that the health or safety of the member is in jeopardy;

Subpoenas are not court orders. Notify the Office of Compliance and Review (OCR) immediately upon receipt of a subpoena for records and forward the subpoena to that office via interoffice mail to Site Code 016F.

G. the right to file complaints;

H. the right to seek correction of records; and

I. should the agency refuse to amend the records, the member or the responsible person shall have the right to a hearing. Should the hearing find favor with the agency, the member or the responsible person shall have the right to insert in the record a statement or explanation.

Consent forms must be time limited and maintained in the central case record. Those consent forms taken during intake expire in 90 days. Subsequent releases are valid for only up to six months. The person signing the consent must have the capacity to understand the nature of the consent. The consent must be voluntary and signed without coercion.

A.R.S.; § 41-1346; § 36-568(01); § 36-551(01)
A.A.C. R6-6-102

1803 Release of Information

An authorized list of persons or titles who may have access to personally identifiable information shall be maintained and available for public inspection. Consents for the release of personally identifiable information, must be:

A. obtained from the member or responsible person in writing and dated); and

B. maintained in the case file.

Consents for the release of information, obtained during intake, expire within ninety (90) days. Subsequent consents should be obtained on an as-needed basis, and are valid for no more than six (6) months.

Refer to this Policy Manual or more detailed information regarding forms used for informed consent.

42 CFR 483.410(c)(3)
A.R.S. § 36-568(01)
A.A.C. R6-6-104

1804 Access to Personally Identifiable Information

A Record of Access documents all requests for receipt and review of confidential information. The confidentiality officer is responsible for assuring that a Record of Access is maintained for each member in service. Requests for information by other State agencies, local or State officials, organizations conducting approved studies, advocacy groups or accrediting organizations will be honored, with **ALL** personally identifying information deleted.

While DES/DDD does not require a standardized Record of Access form, all Record of Access documents shall include:

A. requestor's name;

B. date information copied/sent;

C. purpose for request;

D. specific information released;

E. where information was sent; and

F. verification of consent.

A Record of Access is not required for the following:

A. membermember/responsible person or their written designee;

B. federally authorized members including AHCCCS and DHS staff; or

C. direct care staff, Qualified Intellectual Disabilities Professional (QIDP)s or Support Coordinators in the performance of their job duties.

The confidentiality officer must ensure a Log Book which documents the names of persons, other than Support Coordinators or supervisors, reviewing the case record and date/time of the review is maintained. The Record of Access is typically maintained in the central case record, but may be kept in a location other than the member's master file. In such instances, the Support Coordinator shall document in the master file the required information recorded on the Record of Access (See Master Folder Access Log).

A.A.C. R6-6-103

1805 Lawful Disclosure of Confidential Information

Confidential information shall not be released by any DES/DDD or contract provider staff except as defined below:

A. when the responsible person designates in writing to whom records/information may be disclosed;

B. pursuant to court order;

C. to the extent necessary to make claims on behalf of a member for public/private assistance, insurance, or health or medical assistance to which the member may be entitled;

D. in oral/written communications between professional persons in the provision of services or the referral to services;

E. when disclosure of otherwise confidential information is necessary to protect against a clear and substantial risk of imminent or serious injury to a member;

F. to the superior court when a petition to establish guardianship for the person is filed;

G. to other State agencies or bodies for official purposes. All information shall be released without the designation of the name of the member, unless such name is required by the requestor for official purposes. The State agency or body receiving such information shall regard the information as confidential and shall not release it unless a consent to release information has been obtained from the member/responsibility person;

H. to foster parents and/or persons certified to adopt if necessary to assist in the placement with or care of a child(ren) by such persons;

I. to an officer of the superior court, the Department or any agency required to perform an investigation, if the information is pertinent to the investigation. All information received by the officer, the Department or agency pursuant to this paragraph may be disclosed to the court but shall otherwise be maintained as confidential; and

J. a standing committee of the legislature or a committee appointed by the President of the Senate or the Speaker of the House of Representatives may obtain the information upon written notification to the director.

Any receiver of confidential information is prohibited from using/ releasing the information except in the performance of his/her duties, as defined by statute. Any questions should be referred to the OCR.

A.R.S. § 36-568(01); § 36-29; § 8-105; § 11-2

1806 Violations and Penalties

ANY EMPLOYEE WHO UNLAWFULLY DISCLOSES PERSONALLY IDENTIFIABLE INFORMATION IS SUBJECT TO DISCIPLINARY ACTION OR DISMISSAL. KNOWN VIOLATIONS MUST BE REPORTED TO THE EMPLOYEE'S IMMEDIATE SUPERVISOR AND THE CONFIDENTIALITY OFFICER. VIOLATIONS ARE SUBJECT TO PENALTIES APPLIED BY STATUTE.

A.R.S. § 36-568(01)
A.A.C. R6-6-204

1807 Case Records

Central Case Records

DES/DDD maintains a central (main) case record for each member to whom services are provided. This record contains all pertinent information concerning services provided to an member, and is kept in a location designated by the local confidentiality officer/designee, but usually in the Support Coordinator/QIDP's office. Main case records are available to the member or responsible person upon request, verbally or written.

The Support Coordinator is responsible for making sure that all information generated regarding services to the member, is documented in the central case record. Central case records are required to contain the following:

A. a copy of the member's ISP/Individual Education Plan (IEP);

B. program data and progress notes;

C. the member's identifying information and a brief social history;

D. pertinent health/medical information;

E. current evaluative data/assessments;

F. authorization for emergency care, if appropriate;

G. visitation records, if appropriate;

H. record of financial disbursements, if appropriate;

I. active treatment schedule (ICF/IID);

J. resident fact sheet, if appropriate;

K. periodic dental records, if appropriate;

L. ICAP, if appropriate;

M. documentation regarding the protection of member rights;

N. an accepted diagnosis/diagnostic scheme;

O. documentation of an evaluation that identifies the member's specific needs;

P. reviews/modifications to the ISP/IFSP/IEP;

Q. communication among persons involved with the member and his/her program;

R. documentation of protection of the legal rights of each person served, staff the Department, or contract providers by recording all actions that may significantly affect these rights;

S. documentation to furnish a basis of review, study and evaluation of overall programs provided by DES/DDD;

T. member primary data from ASSISTS; and

U. for members residing in a Nursing Facility(NF) placed on termination status, a primary care physician (PCP) statement that the NF does or does not continue to meet the member's needs, documentation of the member's choice of placement and the reason for non-placement in a NF placed on termination status for a new placement.

Case records, where applicable, shall contain the following additional documentation:

A. of Arizona Long Term Care System eligibility;

B. utilization review report;

C. current photograph of the member;

D. physician's statement of need;

E. Pre-Admission Screening;

F. psychological evaluations/social history;

G. medication history;

H. immunization record;

I. incident, injury, illness and treatment reports including hospital stays;

J. seizure reports;

K. records of contacts/referrals, etc.;

L. an accounting ledger;

M. authorization for emergency care;

N. behavioral health records as described in this Policy Manual; and

O. other pertinent information.

Program/Service Records

Occasionally the delivery of services or a centralized recordkeeping system requires maintenance of separate program/service records. The Confidentiality Officer, Support Coordinator or QIDP is responsible for assuring that files are available at each site where the member receives services, as appropriate, that the Support Coordinator/QIDP has access to such files and that a summary of information contained in such records is entered into the member's main record. These files shall also contain:

A. the name/address and phone number of the physician or health facility providing medical care;

B. reports of accidents, illness, and treatments;

C. reports of significant behavioral incidents;

D. current medication treatment plan;

E. a description of the member's specialized needs;

F. a copy of the ISP/IEP;

G. program data/progress notes;

H. identifying information/social summary;

I. pertinent health/medical information;

J. current evaluative data/assessments;

K. authorization for emergency care;

L. visitation records;

M. records of financial disbursements;

N. active treatment schedule (ICF/IID);

O. resident fact sheet; and where applicable

P. periodic dental reports.

Each member's case record must include current consents. A medical consent signed by the member or the responsible person shall be required in the event of emergency medical care, routine medical care and special procedures.

42 CFR 483.410(c)(1)(6)
A.A.C. R6-6-202(B); R6-6-110(B)(8)(9);
R6-6-114(14)

1808 Documentation Requirements

All documentation entered into a case record must be in ink or typed, legibly written in non-technical terminology if possible and dated and signed by the person making the entry. In case of an error in documentation, cross out the error with a single line and initial it. Do not erase or use "White Out". If room remains on a Progress Note page, draw a line through the remaining spaces after your signature. Each case record shall include a legend for explaining symbols and abbreviations.

The Support Coordinator has primary responsibility for assuring that case records contain all of the required documentation, and that such documentation meets the criteria set forth in this Chapter by being complete, accurate, timely and reflective of the member's programmatic, social, medical, developmental, educational or vocational status.

1809 Records Storage and Security

Internal

Case records for members currently eligible for services from DES/DDD are considered active records. Active files may contain too much information to be confined to one case record. Overflow files may be established and utilized to store non-essential, out- dated information.

Once established, overflow files are considered inactive, and can contain progress notes, ISP's, correspondence, status reports, guardianship records, medical records, etc. The Support Coordinator, QIDP or the Confidentiality Officer must note

in the most current active record that there is an overflow(s) file and indicate where it is stored.

Although these case records can be maintained within DES/DDD in a place designated by the confidentiality officer for a period of time, the Support Coordinator/QIDP should coordinate the transfer of overflow/inactive files to the State of Arizona Records Management Center (813Z), for storage and retention. See this chapter for procedural information.

External

The Records Center is the DES official depository for inactive case records. The Records Center provides storage, retrieval and re-file services for DES.

To transfer inactive files for storage/retention, staff must:

A. review the records retention schedule to determine that the records are appropriate for retention at this time;

B. pack records into standard boxes 15" L X 12" W X 10" H leaving a minimum of two (2) inches of space to permit retrieval;

C. complete a J-239, Des Records Storage Transmittal (Appendix 1800.C) and forward it to the DES Records Center at 813Z;

D. assign a temporary box number to each box and place that number on the small side of the box, but not directly below the handles. The temporary numbers must be consecutive and continue in consecutive order for future pick-up; and

E. upon receipt of a Records Center box number, place that number directly below the handle.

Records Retrieval

To retrieve stored records, complete a J-240, Records Reference Request and send it to DES Records Center at 813Z.

Destruction of Records

Records will be destroyed in accordance with the records retention schedule in compliance with A.R.S. § 12-2297.

1810 Management and Maintenance of Records Related to the Medicaid Line of Business

The Division will maintain all records for a period of five years from the date of final payment under contract with AHCCCS unless a longer period of time is required by law.

For retention of the member's medical records, the Division will ensure compliance with A.R.S. § 12-2297 which provides, in part, that a health care provider shall retain the member's medical records according to the following:

A. If the member is an adult, the Division will retain the member's medical records for at least six years after the last date the adult member received medical or health care services from the Division.

B. If the member is under 18 years of age, the Division will maintain the member's medical records either for at least three years after the child's 18th birthday or for at least six years after the last date the child received medical or health care services from the Division, whichever date occurs later.

The Division will comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

If the Division's contract with AHCCCS is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of the Division's contract with AHCCCS, or costs and expenses of the Division's contract with AHCCCS to which exception has been taken by AHCCCS, shall be retained by the Division for a period of five years after the date of final disposition or resolution thereof.

1900 GUARDIANSHIP AND REPRESENTATION

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1900 GUARDIANSHIP AND REPRESENTATION

1901 Overview

This chapter presents the DES/DDD policies regarding guardianship and representation for individuals with developmental disabilities. The chapter includes information regarding guardianship and conservatorship surrogate parents, authorized representative for ALTCS benefits and representative payee.

1902 Guardianship and Conservatorship

Guardianship is a legal method that is used to insure that a person who is unable to make reasoned decisions has someone specifically assigned to make decisions on his/her behalf. A guardian must be appointed by a court. A conservator refers to a person appointed by a court to manage the estate of a protected person. A person may have a guardian, a conservator or both appointed by the court.

Guardianship or conservatorship for persons with developmental disabilities shall be:

a. utilized only as is necessary to promote the well-being of the individual;

b. designed to encourage the development of maximum self-reliance and independence in the individual; and

c. ordered only to the extent necessitated by the individual's actual mental, physical and adaptive limitations.

A.R.S. § 36-551(17); §14.5101, et seq.; § 36-564(D)

1902.1 Appointment of a Guardian or Conservator

Only a court can determine that someone needs a guardian. Neither the family nor a Support Coordinator can unilaterally or jointly make that determination. However, the individual himself/herself, a family member, or any person interested in his/her welfare may petition the court (file a request for a hearing in a State court) for a finding of incapacity and the consequent appointment of a guardian. The court will appoint an

attorney to represent the allegedly incapacitated person in the hearing unless the individual has his/her own attorney.

It should be noted that under Arizona law, a person with a developmental disability is presumed legally competent in guardianship proceedings until the court makes a determination to the contrary.

The person alleged to be incapacitated shall be interviewed by a person appointed by the court (called a court visitor) and examined by a court appointed physician, psychologist or a registered nurse who will submit written reports to the court. In addition, the court visitor shall interview the person seeking appointment as guardian, and visit the home of both the individual and the proposed guardian.

During the hearing, the individual who is the subject of the hearing, has the right to be represented by an attorney, to be present at the hearing, to see or hear all evidence, to present evidence, to cross-examine witnesses, and to trial by jury. If the individual alleged to be incapacitated or his/her counsel requests, the issue may be determined at a closed hearing.

Before a guardian can be appointed, the court must be satisfied "by clear and convincing evidence" that the appointment of a guardian or conservator is necessary to provide for the demonstrated needs of the individual.

In case of an emergency situation, the court can appoint a temporary guardian and/or a temporary conservator.

If the appointment of a guardian or conservator is required for a American Indian who is a member of an Indian Tribe and who has significant contacts with that tribe, but who is not an Indian child within the scope of federal law, the Arizona Administrative Code requires that the appointment of a guardian or conservator shall first be requested through the appropriate tribal court, if any, unless the request through the tribal court is not in the recipient's best interests as determined by the Individual Support Plan (ISP) team.

A.R.S. § 14-5303-5304; § 14-5310; § 14-5401; § 36-551(01)(H)
A.A.C. R6-6-1401

1902.2 Who May be Guardian

Any competent person may be appointed guardian by the Court. Persons who are not disqualified have priority for appointment as guardian in the following order:

a. spouse;

b. individual or corporation nominated by the person, if in the opinion of the court, the person has sufficient mental capacity to make an intelligent choice for guardian;

c. an adult child;

d. a parent, including a person nominated by will or other writing signed by a deceased parent;

e. a relative with whom the individual has resided for more than six months prior to the filing of the petition;

f. the nominee of a person who is caring for the person or paying benefits to him/her; or

g. a public or private fiduciary, professional guardian, conservator.

The court may give preference for the appointment of a family member unless this is contrary to the expressed wishes of the individual or is not in his/her best interest as determined by the court.

Persons who wish to be considered for appointment as a temporary or permanent guardian or conservator must provide the court with all required information. Specifically, the proposed guardian must disclose any interest in any enterprise providing health care or comfort care services to any individual.

A.R.S. § 14-5311; § 14-5105

1902.3 Duties of a Guardian

A guardian's duties include but are not limited to:

a. encouraging the individual to develop maximum self-reliance and independence;

b. working toward limiting or terminating the guardianship and seeking alternatives to guardianship;

c. finding the most appropriate and least restrictive setting for the individual consistent with his/her needs, capabilities and financial ability;

d. making reasonable efforts to secure medical, psychological and social services for the individual;

e. making reasonable efforts to secure appropriate training, education and social and vocational opportunities for the individual;

f. taking care of his/her ward's clothing, furniture, vehicles and other personal effects;

g. giving consents or approvals for medical or other professional care that may be necessary; and

h. completing all reports required by the court.

To encourage the self-reliance and independence of the individual (the ward), the court may grant him/her the right to handle part of his/her money or property without the consent or supervision of a conservator. This may include allowing the individual to maintain appropriate accounts in a bank or other financial institution.

A.R.S. § 14-5312; § 14-5408(C); § 14-5315

1902.4 Procedures

As part of the annual review, the ISP team shall evaluate the possible need for a guardian and/or conservator for an individual receiving services through DES/DDD. This information must be noted on the ISP form DD-217 - 2 (Team Assessment Summary, cont, Appendix 800.B) under guardianship status.

When there is serious doubt regarding the ability of the individual applying for services or receiving services to make or communicate responsible decisions, every effort must be made to have a judicial determination made regarding the need for guardianship and/or conservatorship.

In the case of minor child where there is no parent or interested party who is willing and able to serve as guardian, the Support Coordinator should refer the child to Child Protective Services (CPS).

If an individual is 18 years of age or older, the parents are not the guardians unless they have been so appointed by the court. Thus, parents cannot continue to sign medical consent forms, etc. for their children who have become of legal age. The parents may wish to pursue guardianship status.

If the Support Coordinator and/or the ISP team believes that a determination of legal competency should be pursued, the Support Coordinator should:

a. explain the need to the individual and/or family;

b. work with the individual/and or family to help them understand the process necessary for obtaining a guardian and/or a conservator;

c. refer the individual and/or family for help, if it is needed, in securing an attorney to handle the proceedings; (referrals, for example, to: Arizona Center for Law in the Public Interest, Community Legal Services, The Arc, etc., Appendix 100.A);

d. if the individual/family is unwilling or unable to seek guardianship, the Support Coordinator must pursue guardianship by:

1. writing a letter to the county public fiduciary where the individual receives services explaining the situation; and/or

2. contacting Adult Protective Service (APS) for assistance (Appendix 100.A).

A.A.C. R6-6-1401

1903 Surrogate Parent

Parental involvement in the planning of a child's Individual Education Plan (IEP) is a federal requirement. For a child who is without a parent willing/able to participate in the child's educational process, federal and State laws provide for the appointment, by the court, of a surrogate parent to represent a child in decisions regarding special education.

A petition for a surrogate parent for a child with disabilities may be made if any of the three following conditions have been met:

a. no parent can be identified;

b. a public agency cannot determine the whereabouts of a parent after having made three reasonable attempts; or

c. the child is a ward of the State and the biological parent is unwilling or unable to consent to special education placement.

A person who is an employee of a State agency which is involved in the education or care of the child is not eligible to be a surrogate parent. Thus, a DES/DDD Support Coordinator cannot be a surrogate parent. Moreover, a DES/DDD Support Coordinator cannot sign an authorization for a special education evaluation or an authorization for services for a child who has a developmental disability.

1903.1 Procedures

If a child who is receiving services through DES/DDD has a surrogate parent, this information must be noted on the ISP form DD-217 - 2 Team Assessment Summary, cont. (Appendix 800.B) under guardianship status and reviewed annually. In addition, the surrogate parent must be part of the ISP team.

A foster parent who wants to be a surrogate parent should work with the Support Coordinator in making a request to the courts. While a foster parent may petition the court to receive an appointment as a surrogate parent, the court is responsible for determining whether a particular individual is able to act as a foster parent and also represent the best interest of the child as a surrogate parent.

If the Support Coordinator believes a surrogate parent is necessary, e.g., the natural parents have relinquished their rights, the Support Coordinator should seek to have a surrogate parent appointed so that decisions regarding the child's education can be made in a timely manner.

The Arizona Department of Education (ADE) has information regarding surrogate parents and usually has a list of persons who have volunteered to be surrogate parents and have already received the required training.

Public Law 105-17
A.R.S. § 15-761; § 15-763, et seq.

1904 Authorized Representative For ALTCS Benefits

If there is a legal representative, that person must file the application for ALTCS benefits or authorize someone else to be the authorized representative. This is a person who is authorized in writing by an applicant or legal representative to represent him/her in the application process.

The authorized representative signs an affirmation to having knowledge of the applicant's circumstances, has been informed and understands the responsibilities which include:

a. providing complete and accurate information to the best of his/her knowledge regarding the applicant's income, resources, household composition, citizenship, residency and medical insurance coverage;

b. providing all documents needed to determine eligibility;

c. notifying the local ALTCS office of any change in the applicant's circumstances within 10 working days of their occurrence;

d. signing any and all forms necessary for completing the application and verifying eligibility; and

e. identifying and filing insurance claims and assigning insurance benefits to AHCCCS.

Generally, a family member or a legally appointed guardian assumes the responsibility of being an authorized representative for an individual applicant. While a Support Coordinator may assist in the process of making application, the Support Coordinator should not be the authorized representative unless absolutely no one else is available. Before agreeing to becoming an authorized representative for an individual applying for ALTCS benefits, the Support Coordinator must have approval from the Support Coordinator's DPM or designee. (See also Chapter 500).

ALTCS Eligibility Policy and Procedure Manual

1905 Representative Payee

A representative payee is an individual who handles Social Security payments and Supplemental Security Income (SSI) payments for an individual who is unable to handle his/her own finances. The Social Security Administration makes the final decision on who is best suited to become the representative payee for an individual. A beneficiary who has a payee may be receiving either a Social Security check or an SSI check, or both.

The Social Security Publication No. 05-10076 entitled "A Guide For Representative Payees: Social Security and SSI" provides an overview of the duties of a representative payee. This pamphlet can be requested from a local social security office. In general, the duties of a representative payee are to decide how benefits can best be used for the beneficiary's personal care and well-being, to keep an accounting of the funds received, and complete all paperwork and forms required by the Social Security Administration.

In the case of a child with a developmental disability who has been adjudicated a ward of the court and is placed in foster care who is also eligible for SSI, DES becomes the representative payee. In this one instance the Support Coordinator is responsible to make the application on behalf of DES to the Social Security Administration as the representative of DES.

In all other situations, DES/DDD believes that parents, relatives, public fiduciaries, and advocacy groups may be in less of a conflict of interest situation that the agency in handling funds for an individual for whom it is providing services. DES/DDD may not become a representative payee for an individual receiving services unless permission has been granted by his/her DPM or designee.

1905.1 Procedures

If an individual with a developmental disability is receiving services through DES/DDD and has a representative payee, this information must be noted on the ISP form DD-217-2 Team Assessment Summary, cont. (Appendix 800.B) under guardianship statutes. In addition, the representative payee must be part of the ISP team, and must actively participate in the completion of ISP form DD-221 Individual Spending Plan (Appendix 800.H). The ISP form DD-221 also must be completed as part of the annual ISP if DES/DDD is the representative payee. (See Chapter 800 for details on the ISP).

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2100 INCIDENT MANAGEMENT

2101 Overview

The purpose of incident management is to assist in promoting the health, safety and welfare of persons with developmental disabilities through active reporting, investigating, tracking and trending of incidents and the implementation of both individual-specific and systemic corrective actions and prevention strategies.

The Division of Developmental Disabilities (Division) has a comprehensive Incident Management System (IMS), which is part of the Focus Quality Management (QM) Incident Management Application. The IMS database; provides the platform for the reporting of incidents; tracking the notification of key personnel and agencies, the assignment of personnel to fact-find incidents, tracking incidents to closure and completing follow-up actions. The IMS is also used for incident trending and analysis.

The IMS captures incidents for all members enrolled with the Division regardless of funding source or whether or not a service was being provided to the member at the time of the incident.

2102 Definitions of Incidents and Serious Incidents

An Incident is defined as an occurrence, which could potentially affect the health and well-being of a member enrolled with the Division or poses a risk to the community. If the incident is determined to be "serious" as defined in this policy, the Serious Incident protocol section of this policy shall be followed.

<u>Incidents</u>

Incidents include, but are not limited to**:**

A. Death of member

B. Potentially dangerous situations due to neglect of the member

C. Allegations of sexual, physical, programmatic, verbal/emotional abuse

D. Suicide threats and attempts

E. Member missing

F. Accidental injuries which may or may not result in medical intervention

G. Violation of a member's rights as stated in this policy manual.

H. Provider and/or member fraud

I. Complaints about a community residential setting, resident or the qualified vendor

J. Allegations of inappropriate sexual behavior

K. Theft or loss of member's money or property

L. Use of emergency measures

M. Medication errors such as:

1. Wastage of a Class II substance

2. Giving medication to the wrong member

3. Wrong method of medication administration

4. Wrong dosage administered

5. Missed medications

N. Community disturbances in which the member or the public may have been placed at risk

O. Serious work related illnesses or injuries (Division employees). (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee].)

P. Threats to Division employees or state property (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee]); and accidents on state property involving non-member/non-employees. (See DES Policy # DES 1-07-02B, Unusual Incident Reporting [Client].)

Q. Environmental circumstances which pose a threat to health, safety or welfare of members such as loss of air conditioning, loss of water or loss of electricity

R. Unplanned hospitalization or emergency room visit in response to an illness, injury, medication error

S. Unusual weather conditions or other disasters resulting in an emergency change of operations

T. Provider drug use

Serious Incidents

A *Serious Incident* is an extraordinary event involving a member, facility or employed/contracted worker. A serious incident poses the threat of immediate death or severe injury to a person, substantial damage to individual or state property, and/or widespread interest in the news media.

Serious incidents include, but are not limited to the following:

A. All deaths

B. A circumstance that poses a serious and immediate threat to the physical or emotional well-being of a member or staff member

C. Severe physical injury that:

1. Creates a reasonable risk of death; or,

2. Causes serious or permanent disfigurement: or,

3. Causes serious impairment of a member's or worker's health

D. Property damage estimated in excess of $10,000

E. Theft or loss of a member's money or property of more than $1,000

F. Reporting to law enforcement officials because a Division enrolled member is missing and presumed to be in imminent danger

G. Reporting to law enforcement officials due to possession and/or use of illegal substances by members or staff/providers

H. A 911 call due to a suicide attempt by a member

I. An incident or complaint from the community that could be or is reported by the media.

2103 Incident Management System (IMS) Definitions

The following definitions are used when entering incidents into the IMS database. Incidents are entered by the type which is the main reason for the incident and category which is the main classification for the incident.

A. *Accidental Injury:* a non-intentional or unexpected injury.

B. *Member Missing:* an incident in which a member without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in his/her Planning Document is missing longer than the plan provides.

D. *Community Complaint*: a complaint from the community that puts a member or the community at risk of harm.

E. Death: "expected" (natural), "unexpected" (unnatural) or "no provider present".

1. *Expected deaths*: may include deaths from long-standing, progressive medical conditions or age-related conditions, e.g. end-stage cancers, end-stage kidney or liver disease, HIV/AIDS, end-stage Alzheimer's/Parkinson's Disease, severe congenital malformations that have never been stabilized.

2. *Unexpected deaths*: include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma/abuse, sudden deaths from undiagnosed conditions, or generic medical conditions, (e.g. seizures, pneumonia, falls) that progress to rapid deterioration.

3. *No provider present:* refers to deaths of members living independently or with family and no provider is present at the time of the death. The "expected" or "unexpected" categories shall be used if a provider is present at the time of death.

G. *Emergency Measure*: the use of physical management techniques (Client Intervention Techniques [CIT] level II) or behavior modifying medications in an emergency to manage a sudden, intense or out of control behavior.

H. *Fact-finding*: a detailed and systematic collection and verification of facts for the purpose of describing and explaining an incident. The process could include: interviews with the member, Provider and/or Division staff; collection and/or review of member and provider documentation; and coordination with investigatory agencies.

I. *Human Rights Violation*: a violation of a member's rights, benefits, and privileges guaranteed in the constitution and laws of the United States and the State of Arizona. Human rights are defined in A.R.S § 36.551.01. Such as a violation of a member's dignity or personal choice, violations of privacy, the right to open mail, send and receive phone calls, access to one's own money, choosing what to eat.

J. *Member*: a person enrolled with the Division of Developmental Disabilities.

K. *Investigation*: collection of facts/information for the purpose of

describing and explaining an incident. An investigation may be completed by law enforcement, Child Protective Services, Adult Protective Services, or other state agencies.

L. *Legal*: an incident of alleged provider fraud/inappropriate billing, member exploitation through using a member to gain monetary or personal rewards, the possession or use of illegal drugs by provider or state staff.

M. *Medication Error*: the administration of medication in an incorrect manner. This includes: giving medication to the wrong member, administering medication in the wrong method, giving the wrong dosage or not administering the medication.

N. *Neglect*: a pattern of conduct resulting in a deprivation of food, water, medication, medical services, shelter, or other services necessary to maintain physical or mental health. Neglect is an intentional health and safety violation against a member, such as lack of attention to physical needs failure to report health problems or changes in health condition, sleeping on duty or failure to carry out a prescribed treatment plan.

For example: in the case of children, the definition includes the substantial risk of harm due to inability or unwillingness of a parent, guardian or custodian to care for the child. This includes; supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, unless the inability of a parent or guardian to provide services to meet the child with a disability is solely the result of unavailability of reasonable services.

O. *Other:* incidents which involve behavioral episodes without the use of physical restraints, hospitalizations or treatment at an emergency medical facility/Urgent care facility due to medical conditions or illness.

Other Abuse: programmatic abuse, verbal/emotional abuse and sexual abuse.

1. *Programmatic Abuse:* aversive stimuli techniques not approved as part of a person's plan. This can include isolation, restraints, or not following an approved plan and/or treatment strategy.

2. *Verbal/Emotional Abuse:* remarks or actions directed at a member enrolled in the Division that are ridiculing, demeaning, threatening, derogatory or profane.

3. *Sexual Abuse:* any inappropriate interactions of a sexual nature

toward or solicited from a member with developmental disabilities.

P. *Physical Abuse*: intentional infliction of pain or injury to a member.

Q. *Property Damage/Theft*: damage or theft of state property in a member-related incident, or the theft or damage of a member's property.

R. *Provider*: any person, entity or person hired by the entity, who is paid, through contract or agreement, to deliver services to any member.

S. *Suicide*:

1. Attempted suicide with medical and/or police involvement

2. Threatened suicide with a statement from a member that they want to commit suicide

T. *A Health Care Acquired Condition (HCAC) inclusive of the Hospital Acquired Condition (HAC):* as described under the Medicare program, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.

1. Foreign object retained after surgery

2. Air embolism

3. Blood incompatibility

4. Pressure ulcers stage III and IV

5. Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burn, electric shock)

6. Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, and secondary diabetes with hyperosmolarity)

7. Catheter associated urinary tract infections (UTI)

8. Vascular catheter-associated infection

9. Surgical site infection following: after coronary artery bypass surgery (CABG), bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, and laparoscopic gastric restrictive surgery) and orthopedic procedures (spine, neck, shoulder and elbow)

10. Deep venous thrombosis or pulmonary embolism (DVT/PE) after total knee or hip replacement (does not include pediatric and obstetric patients)

11. Other Provider Preventable Conditions (OPPC) means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

    i. Surgery on the wrong member

    ii. Wrong surgery on a member and

    iii. Wrong site surgery

2104 Reporting Requirements

When an incident occurs, take whatever actions are necessary to resolve the emergency and implement protective measures immediately for the person's safety, which may include calling 911 or taking other emergency action.

A. As designated by law, medical professionals, psychologists, social workers, Support Coordinators, peace officers and other people who have the responsibility for the care of a child or a vulnerable adult are mandatory reporters.

   Mandatory reporters who have a reasonable basis to suspect that abuse or neglect or exploitation of the member has occurred are required to report such information immediately to a peace officer or protection services worker, (i.e., Adult/Child Protective Services, Tribal Social Services.) Refer to Support Coordination and Incident Reporting in this Policy Manual for additional information regarding mandated reporting.

B. Serious Incidents, as described in this chapter, are to be reported and written as soon as possible, but no later than 24 hours after the incident.

   Within 24 hours of a serious incident, the following actions must be taken:

   1. The provider shall notify the District of the serious incident.

2. District personnel must enter the incident into the IMS database within 24 hours or the next business day if the incident occurs over a weekend or holiday.

3. Notification to Responsible Person, e.g., guardian or family member - The responsible person shall be notified unless otherwise specified in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan). The procedures for notification of the responsible person shall be coordinated between the service provider and the Support Coordinator. The Support Coordinator or designated District staff member shall ensure notification of the responsible person of an incident within 24 hours after the incident. The responsible person shall also be notified of any follow up actions that occurs.

C. All other incidents listed in the definitions section of this policy must be reported to the District by close of the next business day following the incident, and be entered by designated District personnel into the IMS database within 48 hours of notification (if applicable).

D. Incidents occurring after normal business hours must meet the above reporting requirements.

2105 Members At-Risk If Missing

The actions in this section are required when a vulnerable member leaves a Division funded setting without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in their Planning Document is missing longer than the plan provides.

A vulnerable member is defined as a person who is at potential risk of harm while unsupervised in the community. He or she may be a danger to self or others require medication to control a condition such as diabetes or seizure disorder or lack essential survival skills such as the ability to communicate or move safely about the community. The Individual Support Plan team shall assess the potential risk of a member who may leave his or her service site without supervision and shall note the results of that assessment in the Individual Support Plan. If the member has prescribed medication, the Team shall contact the primary care physician and/or psychiatrist to determine if a potential medical risk may arise if the member goes without prescribed medication for any length of time. This shall be noted in the plan.

Unless approval has been obtained from the Division's Assistant Director/Designee, the following must occur:

<u>Provider Responsibilities</u>:

A. When a vulnerable member leaves a Division funded setting without planned alone time is missing and is at risk of harm, or when a member with alone time as defined in their Planning Document is missing longer than the plan provides, the provider staff will:

1. Conduct a search of the immediate area.

2. If the member is not located within 15 minutes, provider staff will notify the program supervisor/other staff to assist with the search.

3. If the member is not found within thirty minutes, the provider must notify law enforcement agencies (e.g. Police, Sheriff's Office) in both the immediate and surrounding communities and the parent/guardian.

4. To assist in locating the member, also contact the following entities during the search: hospitals, shelters, jails and bus stations.

5. If the member is not located within one hour, the provider must notify the Division by speaking directly to Support Coordination staff during regular business hours or by calling the District after hours reporting system on evenings and weekends.

6. The provider will report the following information to the Division and submit a written incident report within 24 hours.

   i. Age of member

   ii. General description of the person

   iii. Time and location of disappearance

   iv. Efforts to locate member

   v. Vulnerability

   vi. Means of communication

   vii. Medical or special needs

   viii. Precursors to disappearance

   ix. Time police and parents/guardian notified

   x. Other entities contacted

   xi. Legal status (e.g., foster care, probation)

B. If the member is located within one hour, the provider will notify the parent/guardian immediately and provide notification to the Division within 24 hours.

Media Involvement

The decision to contact the media for assistance in locating a member will be a collaborative agreement between the Division, law enforcement officials, parent/guardian and the provider.

A. Prior to contact with the media, the provider will obtain verbal or written authorization from the parent/guardian. The approval must be documented in the provider and the Division records.

B. As authorized, the provider will work directly with law enforcement officials by providing essential information about the member to be released to the media. Law enforcement will make the request for release of the vulnerable member's information to the media.

C. Support Coordination will immediately notify the District's Program Manager or designee when a media release is requested.

D. District Program Manager/designee will notify the Division's Assistant Director or designee for notification to the Department's Director and Public Information Officer.

Planning Team Responsibilities

The member's Planning Team will meet to discuss the incident within 30 days or as designated in the Behavior Plan to review the appropriateness of the current plan and Risk Assessment Tool.

2106 Incident Reports

The Incident Management System (IMS) is the computerized database for incidents and reports.

A. All incidents meeting the criteria of the IMS including serious incidents must be entered into the IMS as defined in this policy.

B. Reporting an incident

1. Provider's may use the Division's Incident Report Form to report incidents. Or,

2. A provider's own internal incident report form may be used to

record incidents as defined in this policy.

C. Incident Reports shall:

1. Be written clearly, objectively and in order of occurrence, without reference to the writer's opinion. Incident reports may be available to family/guardians and are considered legal documentation.

2. Include demographic information (i.e., full name, address, date of birth and Focus ID number) about the member.

3. Include the names and job titles of staff that witnessed or were involved in the alleged incident.

4. Include a description of the incident including all known facts, location and the date and time incident occurred.

5. Include causes of injury (if applicable).

6. State whether or not the responsible person was notified and, if not, why.

7. Include whether or not law enforcement, Adult/Child Protective Services or Tribal Social Services were contacted.

8. Include signatures and names of the person completing the report and his/her supervisor and any additional comments.

9. Be completed for each individual involved in the incident and reference other individuals by initials only.

10. Be included in the member's primary record maintained by the Support Coordinator and by the provider completing the report.

2107 Fact Finding

The Division may initiate a fact-find of any incident. Except when such action would compromise the legal investigation by law enforcement, Protective Services or another State Agency (i.e., DES Office of Licensure, Certification and Regulation) the Division should notify the service provider of the onset of a fact find.
Service providers shall ensure that any service provider worker alleged to have endangered the health or safety of an individual shall not have direct contact with any individual served by the Division, pending the outcome of the Division's fact finding activities.

Division staff is responsible for notifying and assigning appropriate personnel to initiate fact-finding.

The District Program Manager is responsible to assign only qualified Division personnel to complete a fact-finding. Division personnel assigned to conduct a fact finding will meet the following qualifications:

A. Have demonstrated ability to be objective;

B. Can maintain confidentiality;

C. Can complete the task within the assigned period;

D. Have expertise regarding the particular situation; and,

E. Have no conflict of interest involving the situation.

The staff assigned to complete fact finding of any incident must have successfully completed fact-finding training offered by the Division.

When a fact-finding of an incident occurs, the following apply:

A. Protective measures must be taken immediately for the person's safety.

B. Initiation of the fact-finding occurs within 24 hours of notification or the next business day for the following incidents:

1. Allegations of physical abuse which results in medical treatment or police involvement

2. Allegations of sexual abuse

3. High risk incidents of member missing

4. Attempted suicide

5. Unexpected deaths

6. Allegations of neglect that involve imminent danger

7. Accidental injuries involving hospitalization

C. Fact-Findings are initiated within 10 days of notification for:

1. Allegations of physical abuse which do not result in medical/police intervention

2. Allegations of verbal/emotional or programmatic abuse

3. Community complaints

4. State property damage or theft above 100 dollars

5. Member property damage or theft over 25 dollars

6. Expected deaths

7. Allegations of human rights violations

8. Allegations of neglect that involve potential danger

9. Accidental injuries that resulted in medical intervention

10. Legal issues involving allegations of fraud, member exploitation or provider drug use.

The fact-finding may involve a review of the provider's incident reports, as well as a review of other records maintained in the provision of services. A fact-finding will typically include interviewing the person reporting the incident, the service provider, and/or members who might have additional information or insight regarding the incident.

If an external investigation is initiated, the Division may delay its fact-finding until Office of Special Investigations, Department of Child Safety (DCS), Adult Protective Services, Tribal Social Services, law enforcement personnel, or other State Agencies (e.g.,: DES Office of Licensing Certification and Regulation [OLCR]) have completed their investigation, to avoid potential conflicts. If another agency is involved, the assigned Division employee must coordinate efforts with that agency.

Conclusion of the Division's fact-finding shall be within 30 days from notification date of the incident. A fact-finding can be extended an additional 30 days twice for a total of 90 days if more time is needed to allow DCS, Adult Protective Services, Tribal Social Services, law enforcement or other state agencies to complete their investigation and provide the results to the Division.

2108 Abuse and Neglect

Definitions

Abuse:

A. Intentional infliction of physical harm;

B. Injury caused by negligent acts or omissions;

C. Unreasonable confinement or unlawful imprisonment; and,

D. Sexual abuse or sexual assault.

Abusive treatment:

A. Physical abuse by inflicting pain or injury to a member. This includes hitting, kicking, pinching, slapping, pulling hair, or any sexual abuses;

B. Emotional abuse which includes ridiculing or demeaning an member, making derogatory remarks to an member or cursing directed towards an member; and,

C. Programmatic abuse which is the use of an aversive stimuli technique that has not been approved as part of such person's Individual Support Plan (ISP) and which is not contained in the rules and regulations adopted pursuant to A.R.S. § 36-561(B). This includes isolation or restraint of a member.

Child, youth or juvenile: a member who is under the age of eighteen years.

Exploitation: the illegal or improper use of an incapacitated or vulnerable adult or his/her resources for another's profit or advantage.

Incapacity: an impairment by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate informed decisions concerning his/her person.

Neglect: a pattern of conduct without the person's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health. Neglect also means:

A. Intentional lack of attention to physical needs of members such as toileting, bathing, meals, and safety;

B. Intentional failure to report health problems or changes in health condition to immediate supervisor or nurse;

C. Sleeping on duty or abandoning work station; and,

D. Intentional failure to carry out a prescribed treatment plan for a member.

Physical injury: the impairment of physical condition and includes but shall not be limited to any skin bruising, pressure sores, bleeding, failure to thrive, malnutrition,

dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ or any physical condition which imperils health or welfare.

Serious physical injury: physical injury which creates a reasonable risk of death or which causes serious or permanent disfigurement, or serious impairment of health or loss or protracted impairment of the function of any bodily organ or limb.

Vulnerable adult: a member who is eighteen years of age or older who is unable to protect himself/herself from abuse, neglect or exploitation by others because of a mental or physical impairment.

Department of Child Safety (DCS)

When a Support Coordinator suspects abuse or neglect, as a mandated reporter, the Support Coordinator must immediately report to DCS. Additionally, any allegation of abuse or neglect must be reported in accordance with A.R.S. §13-3620 as outlined below. Upon reporting, the Support Coordinator should provide sufficient information regarding the alleged abuse and/or neglect to allow the DCS worker to set the appropriate priority to the case. The Support Coordinator shall cooperate during investigations and follow-up as required.

Reports made regarding American Indians will be in accordance with tribal procedures.

Reports

Reports made to DCS shall contain:

A. The names and addresses of the minor and his/her parents or person or persons having custody of such minor;

B. The minor's age and the nature and extent of his/her injuries or physical neglect, including any evidence of previous injuries or physical neglect; and

C. Any other information that such person believes might be helpful in establishing the cause of the injury or physical neglect.

A copy of the Incident Reporter the Child Abuse Reporting Form will be forwarded to the DCS Hotline within 24 hours.

Incident Report

When the Support Coordinator reports alleged abuse or neglect to DCS, the Support Coordinator shall complete an Incident Report (IR) in the Incident Management System.

The District will ensure the DCS Program Manager receives an information copy of all IRs on DCS referrals from Division staff.

When DCS staff reports alleged abuse or neglect made by someone other than Division staff, the Support Coordinator will complete and forward an IR.

Investigative Procedures

It is the responsibility of DCS to determine whether an investigation of the allegation is necessary and to proceed with the investigation. The Support Coordinator shall receive the results of the investigative decision by DCS. If, subsequent to an investigation, DCS opens a case, the Support Coordinator shall participate in a team staffing to develop a collaborative plan.

Working with DCS

The Support Coordinator shall work as expeditiously as possible with the DCS worker to resolve any concerns regarding a report or investigation made to DCS.

Whenever possible, the Support Coordinator shall meet in person with the DCS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly and satisfactorily resolved at the Support Coordination level. Supervisory and/or management staff shall immediately pursue the steps necessary to resolve the issues.

Adult Protective Services

In accordance with A.R.S. §46-454, as a mandated reporter, the Support Coordinator or other Division staff shall immediately report any suspicions/allegations of abuse, neglect or exploitation of an adult to Adult Protective Services (APS). APS responds to allegations of abuse, neglect, or exploitation according to the following requirements the person:

A. Is 18 years of age or older; and

B. Is a vulnerable adult as defined in A.R.S. § 46-451.

Reports

Reports made to APS shall contain:

A. The names and addresses of the adult and any persons having control or custody of the adult, if known;

B. The adult's age and the nature and extent of his/her incapacity or vulnerability;

C. The nature and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property; and

D. Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

A written follow-up report shall be mailed or delivered to the police officer or local adult protective services worker within 48 hours or on the next working day if the 48 hours expire on a weekend or holiday.

When the member resides in his/her own home, a family residence, or an agency not funded by the Division, APS will take the lead for the investigation. APS will work together with the Support Coordinator or other Division staff as appropriate. Specific responsibilities are decided on a case-by-case basis. The APS worker will remain involved until the abuse or problem situation has been resolved.

When the adult resides in a DES/DDD operated or funded program, APS will investigate the complaint. DES/DDD is responsible for coordination with APS and notification of the fact finding process. DES/DDD staff, as appropriate, will conduct a fact- find to determine program and contract compliance issues.

Incident Report

When a report is made to Adult Protective Services, the Support Coordinator shall complete an Incident Report, following procedures established in this policy manual.

Working with APS

The Support Coordinator shall work as expeditiously as possible with the APS worker to resolve any concerns regarding a report or investigation made to APS.

Whenever possible, the Support Coordinator shall meet in person with the APS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly and satisfactorily resolved at the Support Coordination level. The Support Coordinator shall cooperate during investigations and follow-up as required. Supervisory and/or management staff shall immediately pursue the steps necessary to resolve the issues.

2109 Referral to Other Investigative Agencies

The Assistant Director or the Office of Compliance and Review may refer incidents for investigation to the DES Office of Special Investigations. An external investigation request may be made for incidents involving:

A. Potential criminal activity

B. Possible misconduct by a Division or service provider's employee

C. Fraud (this type of incident will also be referred to AHCCCS, as appropriate).

2110 Incident Closure and Corrective Actions

A. An incident is complete when:

1. The fact finding if needed is reviewed and approved by the Division.

2. Recommendations for corrective action are identified and provided to appropriate Division and provider personnel.

3. Corrective action plans, if needed, are requested .and received from the provider and approved by the Division.

4. Designated District personnel have verified the information entered into the IMS database and have verified that all corrective actions have been completed no later than 60 days from the acceptance of for a plan.

B. Corrective actions may be member-specific or systemic.

An example of a member-specific corrective action would be requiring the person's Planning Team to reconvene to discuss the incident and review the need for any changes in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan) to ensure the health and safety of the member.

Systemic corrective actions may require the provider to rewrite or clarify agency policy, procedure, recommend specialized training of staff, or require other quality improvement actions to increase the ability of the provider to improve the health and well-being of members served.

C. The member's Planning Team shall review all incidents for the effectiveness of services and assess risk as part of the Planning Document and update the process.

D. The Division's Program Monitoring staff (at the Central Office and District Level) shall review all incidents for residential placements and day programs to be monitored prior to the visit to identify any areas that may warrant extra monitoring.

2111 Trending for Quality Improvement

Trending is an essential component of the IMS.

District Quality Management lead will compile District specific quarterly data analysis reports and submit to the Quality Management unit. The content will include at a

minimum:

A. Total incidents by type and category, provider and member

B. Trends by provider and member including:

i. Total allegations of abuse, neglect and exploitation,

ii. Information of whether or not the allegation was substantiated

C. A narrative analysis of findings, patterns, areas of concern and recommended actions for quality improvement

The Division's Central Office designee will prepare a Statewide Incident Summary Report monthly and annually and will include at a minimum:

A. Total incidents by type and category by district,

B. Trends by provider and member including:

i. Total allegations of abuse, neglect and exploitation,

ii. Information of whether or not the allegation was substantiated

C. In a narrative format an analysis of findings, patterns, areas of concern, and recommended actions for quality improvement

Incident Summary Reports will be provided to the Quality Administrator, the Assistant Director and to designated personnel.

The Division Management Team and Statewide Quality Management Committee will formally review the summary reports on a quarterly basis.

If the District or Statewide Incident Summary Reports indicate any areas of concerns or patterns, focus studies will be completed by the Central Office designee, District Quality Management leads or designee. If the focus study confirms any areas of concerns or patterns, corrective actions will be recommended for quality improvement.

2112 Information Sharing

Incident reports may be made available to:

A. The Human Rights Committees as prescribed in this policy manual;

B. The member/responsible person(s);

C. Others who are bound by confidentiality on a need to know basis; and,

D. All requests should be directed to the Office of Compliance and Review.

Fact finding reports and action plans are confidential. Fact finding and corrective action plans are summarized in the IMS Fact Finding screens.

2113 Mortality Review Audits

Computer and desk audits will be conducted to determine the timeliness and accuracy of reports, investigations and implementation of corrective actions involving the death of a member. Quality reports of the system will also be used to identify patterns of user concerns, e.g. entering an incident into the incorrect type or category, common data entry errors, that indicate the need for additional training, technical assistance or management information system change.

2114 Mortality Review Process

The purpose of this policy section is to improve quality of care for members by a systematic examination of deaths.

Notification Procedure

When a death is reported to a Support Coordinator, the Support Coordinator will forward the information to their District Quality Unit's IR Central for entry into the IMS database within 48 hours of notification of a death.

Once the Support Coordinator is alerted to an incident, they will notify the responsible person or next of kin, if they have not already been notified. The Quality Assurance manager or designee will also immediately notify the appropriate District Manager or designee within 24 hours of the Division's notification of a member's death. All service authorizations must be closed in Focus with the date of death as the effective date by the Support Coordinator. Support coordination (CMG/CPG) and Bereavement Counseling is offered to the family may remain authorized for days after the Division was notified of the death. If staff becomes aware of any service utilization after the date of the member's death, it should be reported into the Incident Management System.

If Health Care Services staff is notified of a death, they will notify the Central Office on-call person within 24 hours.

The District Manager or designee will notify the Assistant Director/designee or the Division's on-call line within 24 hours of being notified of a death, as well as the Adult or Child Protective Services agency as required by statute. The District Manager or designee will also notify the Human Rights Committee District liaison.

Central Office designees will notify the Department of Administration (DOA) Risk

Management if the death may give rise to a liability claim against the state.

Review Procedure

A. District Review

1. All deaths are to be reviewed jointly by the Support Coordinator and his/her supervisor within 30 days, to identify apparent issues relating to care or cause of death.

2. The Support Coordinator or designee will enter the following information, as applicable, relating to the death into the IMS database:

   i. Member's underlying primary medical conditions

   ii. Detailed circumstances of the death Date of Death? What happened? Where did it happen? Was a provider present? Did providers follow policy such as calling 911 and performing CPR? Had the member been ill? Was the member recently seen by PCP? What symptoms of illness did the member have? What is the suspected cause of death (if known)?

   iii. Was Hospice involved?

   iv. Did the member have an Advance Directive in place?

   v. Had DCS/Adult Protective Services (DCS/APS) been involved within the last year?

   vi. Is there litigation pending?

   vii. Is there further fact-finding pending?

   viii. Was the family/guardian notified?

   ix. Did the Division offer support/grief counseling for the family?

3. The District will send the primary case file to Central Office Health care Services within 60 days after being notified of the death.

B. Health Care Services Quality Assurance Investigative Nurse (HCS QA Nurse) Review

1. The HCS QA Nurse reviews the mortality information documented in the IMS database and requests further information, as

necessary.

2. The Chief Medical Officer assigns the death into one of the following categories:

Level A These include deaths that are expected and/or anticipated, due to natural causes, such as terminal illness or congenital anomalies. Level A deaths typically would also include members who lived with family or independently and were not receiving any services from the Division at the time of death.

Level B These include deaths that are not expected and/or are sudden, such as trauma or pneumonia that progresses to respiratory failure. These deaths require a closer inspection into the circumstances surrounding the death and assessment of any systemic issues which should be addressed. Other situations where Level B is indicated include: aspiration, coroner cases, law enforcement/911 calls, decubitis, methicillin-resistant staphylococcus aureus (MRSA), unexpected circumstances, unusual or suspicious circumstances, and problems with emergency or other medical care.

C. The HCS QA Nurse requests death certificates and when indicated, autopsy reports.

D. The HCS QA Nurse gathers additional medical records for review when indicated.

E. The HCS QA Nurse tracks mortality information in a database specifically designed to collect information related to member deaths.

F. The Chief Medical Officer communicates via IMS the status of the mortality review and when the case is considered closed. The Chief Medical Officer shares any recommendations in the summary.

G. Based on the information reviewed by the Chief Medical Officer, cases will be selected from the Level B deaths to present to the Mortality Review Committee at their next quarterly meeting. The selected cases warrant additional review by the Committee and demonstrate situations where systemic improvement may be made.

Mortality Committee Review

A. The Committee shall discuss each case selected and identify changes to

practice, training, or processes that may positively affect care and treatment. The Committee shall report in writing their recommendations to the Management Team.

B. Within 30 days of receiving a recommendation from the Committee, the Management Team shall report their disposition and intended steps to respond to recommendation(s).

C. Following the Mortality Review Committee review, the case shall be closed unless it is referred for Level C review.

Review Level C – Root Cause Analysis Review

A. Root Cause Analysis, which will follow the general protocols recommended by the Joint Commission on Accreditation of Health Care Organizations, will be arranged by the Chief Medical Officer and will be conducted on cases recommended to the Assistant Director by the Mortality Review Committee or as requested by the Assistant Director.

B. No more than 3 Root Cause Analyses shall be conducted in a fiscal year.

C. The HCS QA Nurse shall monitor the implementation of recommendations from a Root Cause Analysis.

Process

A. The Mortality Review Committee shall meet at least quarterly.

B. The Chief Medical Officer shall issue annually a Mortality Review and Analysis, which will aggregate, analyze and summarize mortality data and actions taken for system improvements.

C. The HCS QA Nurse is responsible for monitoring the mortality review process and conducting integrity checks, including protecting any privacy rights of the deceased.

D. Autopsies should always be requested for children in foster care. For all other deaths, requests should be made whenever it is possible that something can be learned about the death. Consent for an autopsy rests with the responsible person or next of kin, unless the county attorney or coroner is involved. A request for an autopsy should follow these steps in priority order:

1. Arizona Revised Statute 11-597 (www.azleg.gov/) provides for County Medical Examiners to complete an autopsy and outlines when this is required.

2. When the Medical Examiner does not identify a need for an autopsy, the Division can request the family to authorize an autopsy, at the expense of the Division, when the Division's Chief Medical Officer believes there are unanswered questions surrounding the death.

3. Autopsy reports will be requested by the HCS QA Nurse.

E. Death Certificates will be requested by the HCS QA Nurse.

F. Reviewers and all others involved with these processes shall in all cases exhibit compassion and sensitivity to next of kin, caregivers, and others who cared about the member.

2115 Fraud and False Claims

Overview

This section defines fraud and describes the procedures for prevention, detection and reporting of fraud, false claims and abuse within the Division.

Policy Objectives

The objectives of this policy are to:

A. Prevent or detect fraud and abuse

B. Delineate reporting requirements

C. Define investigative procedures

D. Explain corporate compliance

E. Describe training requirements

F. Specify policy requirements for providers

Definitions

Abuse: related to this section, practices which are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Division or in reimbursement for services which are not medically necessary or which fail to meet professionally recognized standards for health care.

Fraud: "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or

another person. It includes any act that constitutes fraud under applicable federal or state law." (42 CFR 455.2)

An act of fraud has been committed when a member or provider:

A. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.

B. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.

C. Conspires with others to get a false or fraudulent claim paid by the Federal Government.

D. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the Federal Government.

42 CFR 455.2 www.gpoaccess.gov/cfr
ARS §§13-1802; 13-2002; 13-2310; 13-2311; 36-2918, www.azleg.gov/

Potential: based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

Preliminary Fact--Finding Investigation: when the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practices, it may conduct a preliminary fact-finding to determine whether there is sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

Prevention: keep something from happening.

Primary Contact: the central person within the Division who is charged with the responsibility to report potential incidents of fraud and abuse to the Arizona Health Care Cost Containment System (AHCCCS) in the manner prescribed in this policy.

Provider: a person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division's Policy Manual, All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

A.A.C. Title 6, Chapter 6, Articles 8, 10, 11, and 15
www.azsos.gov/public_services/rules.htm

Remit Advice: a document detailing the status of each line item in a provider claim, by member specificity. It reports the resolution for each line as paid, denied, or pended. Reason codes are attached and summarized for those lines denied.

Prevention and Detection

The Division has established internal controls on the member payment system including claim edits and prior authorization requirements. The Division produces reports to review high utilization by members (CLT_0060), underutilization by members (CLT_0150), service cost, and units by service title, month by month over the fiscal year and other reports for analysis. The Business Operations Unit as outlined below conducts a post-payment review process.

A. Claims Edits

All claims are edited through a computerized system. When a claim is entered in the system for payment the system checks to ensure that a completed authorization is in place. System edits prevent payment for incomplete or absent authorizations and/or duplicate claim submittals.

The Division also segregates the functions of service authorization and claims processing.

B. Post Processing Review of Claims

The Division reviews detailed "remit advices". Additionally, the Auditor General performs an annual audit of the ALTCS program including claims processing and payment.

C. Prior Authorization

All services are prior authorized. Prior authorization occurs within the guidelines set forth in this policy manual and the AHCCCS Medical Policy Manual.

D. Utilization/Quality Management

The Division complies with the requirements set forth in the AHCCCS Medical Policy Manual.

E. Contract Provisions

All providers shall comply with the "Uniform General Terms and Conditions" and the "Special Terms and Conditions" of the Qualified Vendor Agreement or the terms of the Independent Provider's "Individual Service Agreement".

F. Reporting

The Division enters all reports of suspected fraud or false claims into the Incident Management System (IMS). The incidents are reviewed, trended and reported as required.

The IMS is the tracking system for any suspected fraud or false claims reported by providers, members, or staff. Fraud can be reported to the Division by anyone in writing or by phone. Reports can also be made by calling the appropriate District Office. The Office of Compliance and Review can be contacted directly to report fraud as well as by calling

1.866.229.5553 or submitting information to:

Division of Developmental Disabilities
Office of Compliance and Review
3443 N. Central Ave., 9th Floor, Ste 916 – Site Code 016F
Phoenix, AZ 85012

All the Division employees and providers shall comply with this chapter. The Manager of the Division Office of Compliance and Review shall report potential incidents to AHCCCS utilizing the AHCCCS prescribed form.

False Claims Act (FCA)

The False Claims Act (FCA) covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $5,500 to $11,000 for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award the person must file a "qui tam" lawsuit. An award is only issued if, and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

The "whistle blower" is protected under the FCA. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole.

Any provider receiving at least $5,000,000 in annual payments through the Division; shall establish written policies for all employees regarding Fraud and the FCA requirements.

Corporate Compliance

The Corporate Compliance Officer implements, oversees and administers the Division's compliance program including fraud and abuse control. The Corporate Compliance Officer shall be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.

The Division reviews, analyzes and trends fraud and false claims through the monthly Corporate and Quality Data Analysis Committee. The committee includes the Chief Medical Officer, Quality Management Administrator, Quality Assurance staff, Office of

Compliance and Review Manager, Consumer Resolution Unit, ALTCS Administrator and Business Operations Administrator. The monthly agenda includes a review of all Incident Management System data for the past month (including suspected fraud); Consumer Resolution System data for the past month; Program Monitoring reviews for the past month; claim disputes, appeals and state fair hearings for the past month; and any other data available, including results from post-payment reviews. The committee will make recommendations for improvement of the compliance program as identified through the analysis and review of reports. The Office of Compliance and Review Manager also meets quarterly with the Assistant Director to review any pending litigation, including a review of all fraud or false claim reports. The Office of Compliance and Review Manager reports any suspected fraud or false claims incidents to the appropriate AHCCCS entity as required by contract and/or AHCCCS policy.

Training

The Division has available training through both the continuous core curriculum as well as Computer Based Training regarding the False Claims Act. In addition, the Office of Compliance and Review provides on-going standalone training to each District regarding compliance issues including the False Claims Act. The Division has contract language requiring Qualified Vendors to comply with the Deficit Reduction Act including providing training to their employees.

2116 Health Care Acquired Conditions (HCAC)

Identification and Reporting

Any HCAC occurrence that has been identified and verified will be entered into the Division's Information Management System (IMS) by the Health Care Services (HCS) Quality Assurance Registered Nurse/designee who has the final determination of confirmed HCAC occurrence and will enter each confirmed HCAC as an Incident Report (IR) within twenty-four (24) hours of confirmation. These IR's will be reviewed on a daily basis for reporting to AHCCCS by the Division's HCS Quality Assurance Registered Nurse. In addition, a report could be made to the appropriate regulatory boards and agencies (Arizona Department of Health Services, Arizona Medical Board, and Arizona State Board of Nursing).

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2200 GRIEVANCE AND APPEALS

2201 Overview

This chapter sets forth the procedures for proper notice of intended action, informal resolution of complaints, administrative review, grievances, hearings and appeals.

Members with the Division of Developmental Disabilities (the Division) have grievance and appeal rights afforded to them under both the state program and the Arizona Long Term Care System, dependent upon their eligibility and the matter of dissatisfaction.

2202 Definitions

Action: a written decision made by the Division not agreed upon by the member/responsible person, when Arizona Long Term Care System (ALTCS) actions include:

A. service denial or a limited authorization (an authorization in an amount, duration or scope less than what is ordered or requested) of a requested service, including the type or level of service, is granted; or

B. a previously authorized service is reduced, suspended or terminated; or

C. payment for a service, in whole or in part, is denied in accordance with the Arizona Administrative Codes; or

D. authorization of services not initiated in a timely manner; or

E. a request by a member, who resides in a rural area with only one health plan, is denied his/her right to obtain services outside the network.

ALTCS Notice of Action: the written notice to the affected member regarding an action by the Division.

Appeal: formal process under Arizona Long Term Care to request a review of an action taken by the Division.

Administrative Decision: the formal decision made by the Office of Compliance and Review (OCR) related to a state funded service, including eligibility

Administrative Review: formal review and investigation of the stated issues conducted by the Office of Compliance and Review (OCR) or assigned designee.

Grievance: a member/responsible person's expression of dissatisfaction with any aspect of a member's care not involving an action.

Notice of Intended Action: a letter from the Division related to a state funded service informing the member/responsible person of the decision and the member/responsible person's due process rights.

Notice of Appeal Resolution: the formal written decision made by the Office of Compliance and Review (OCR) regarding an ALTCS covered service.

2203 Informal Resolution/Grievance Process (Non-ALTCS)

A member/ responsible person may have a grievance or expression of dissatisfaction with any aspect of his/her care such as a quality of care issue or problems related to communication or courtesy. A member or his/her responsible person will be encouraged to discuss any problems with the Support Coordinator as soon as they arise to seek resolution. The Support Coordinator is responsible for reviewing the grievance(s) and attempting to resolve it informally before the grievance is elevated to the Office of Consumer and Family Support.

If necessary, the Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution.

If needed, the DPM or designee may assist in the informal resolution. At any time, the member or his/her responsible person may contact the Support Coordinator's Supervisor or Program Manager.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or his/her responsible person of the process for filing a grievance in person, by telephone or in writing. The Support Coordinator's responsibilities do not extend to preparing the document for the member or the responsible person.

The Support Coordinator must document the member's complaint, the Support Coordinator's attempts to resolve the complaint, and that the member or his/her responsible person was advised of his/her right to file a grievance and the process for doing so. This documentation should be included in the progress notes.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Office of Consumer and Family Support will advise the member or his/her responsible person in writing of the resolution of the grievance no later than ninety (90) calendar days from the receipt of the grievance and will record all results in the Consumer Resolution Tracking System.

2204 Appeal Process for Members Who Receive State Funded Services

When a decision is rendered by the Assistant Director (AD) with which the member or his/her responsible person does not agree, he/she may file a request for a hearing by the DES Office of Appeals. The appeal request must be made in writing and received by OCR no later than 30 calendar days after the postmark date of the decision letter. The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

Once the hearing request is made, OCR staff will prepare a duplicate file for submission to DES along with the hearing request. This file will include copies of the Notice of Intended Action, request for administrative review, investigative materials, and the decision letter.

DES representatives will schedule the hearing and the member/responsible person will be notified of the date and time of the hearing in writing. DES will also notify OCR of the hearing schedule.

At the hearing, the member or his/her responsible person, including any legal representative and a Division representative will meet with a DES Hearing Officer. This hearing is informal and the rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence and the record supplied by OCR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision in writing. Any member adversely affected by the decision will be notified (by the Hearing Officer) of the right to appeal the decision.

An appeal of the Hearing Officer's decision, if requested, must be made to the DES Office of Appeals no later than fifteen (15) calendar days after the date of the decision. The request must completely explain the grounds on which the appeal is being made.

Appeal requests should be sent to:

DES Office of Appeals
1951 West Camelback Road, Suite 360
Phoenix, Arizona 85015

The DES Office of Appeals/Appeals Board (the Board) will decide the appeal. The

Board will issue a final written decision on the matter within a reasonable time period.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the DES decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

2205 Notice of Intended Action (State only)

A Support Coordinator or District representative must issue a written Notice of Intended Action to any member/responsible person who receives services from DES/DDD that is not eligible to receive Arizona Long Term Care System (ALTCS) services, or the service is not an ALTCS covered service.

State only actions include:

A. Service denial, change, reduction or termination; or

B. eligibility is denied or terminated.

The notice must be issued on the Division form, *Notice of Intended Action or Service System Discharge,* and include the following information:

A. the name and address of the responsible person;

B. the date that the notice is mailed;

C. the name of the member affected by this action;

D. the action that is being taken;

E. the effective date of the action;

F. the reason for the action;

G. what the member/responsible person can do if he/she does not agree with the action being taken; and

H. the signature of the person authorized to make the decision regarding the determinations noted previously.

Every effort must be made to explain the action using vocabulary the member/responsible person will understand. The notice will be written in English and when appropriate and reasonably possible to do so, in the primary language of the recipient. If the recipient cannot understand the notice, the recipient may call the Support Coordinator for assistance with translation.

A.R.S. § 36-563
A.A.C. R6-6-1802

2206 Administrative Review Process (State Only)

If the member or his/her responsible person does not wish to pursue informal resolution of his/her complaint, or the informal resolution process was not successful, a request for administrative review can be made. This request must be made within 35 calendar days of the attempted informal resolution or written notice of intended action. If there was no informal resolution process or written notice, the member or his/her responsible person has 35 calendar days from the date of the initial problem to request an administrative review.

The request should be made either in writing or by telephone to the Office of Compliance and Review. Verbal requests will not be accepted.

Whatever manner of request for a review is used, the following information must be given:

A. Member's name, date of incident, address, identification number, birth date and health plan, if appropriate.

B. Responsible person's name, relationship and telephone number.

C. Support Coordinator's name and telephone number.

D. Physician's name, if applicable.

E. Statement of the nature of the complaint and the action requested.

All written requests for Administrative review should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

OCR will complete a review and investigation of the stated issues. OCR staff will submit a request for facts to the District office. Any documentation of the administrative review must be returned to OCR within 5 calendar days.

OCR staff will then contact the member or his/her responsible person, medical providers, service providers and/or District staff to obtain additional information. Relevant policies will be reviewed and Central Office staff will be consulted as necessary. Once the fact finding is complete, a written decision will be rendered to the member or his/her responsible person within thirty (30) calendar days of receipt of the member's administrative review request.

There will be no change in the member's status or the services he/she receives while the administrative review is occurring. An exception may be allowed under certain circumstances (i.e., a member may need additional services and/or care if

necessitated by a change in health status).

A.R.S. § 36-563
A.A.C. R6-6-1803

2207 Fair Hearings and Appeals

Further appeal options depend on whether the member is ALTCS eligible or whether he/she receives state funded services. There are common components to the two appeal processes, which include:

A. The hearing must be held at the established hearing location that is most convenient for the member or responsible person. The member and his/her responsible person must be informed of the date, time, and location of the hearing no less than 20 calendar days in advance for standard requests. At the discretion of the hearing officer, the hearing can be conducted by telephone.

B. The hearing notice must state that the member or responsible person has the right to:

   i. present his/her case in person or by telephone;

   ii receive a copy of all case file documents, and any material that the Division will use in the hearing at a reasonable time before the hearing;

   iii. obtain assistance from the Division local office in preparing his/her case;

   iv. make inquiry at the Division local office concerning the availability of free legal resources; and

   v. request a change of the hearing officer.

C. Hearings must be conducted in an orderly manner by the hearing officer. The hearing officer can rule on the admissibility of evidence, and include or exclude witnesses. Parties may present evidence, cross examine witnesses and present arguments.

D. A complete record is made of all hearings. The member and his/her responsible person may inspect the record at a location that is accessible to them.

E. The hearing decision must be based solely on the evidence and testimony presented at the hearing, appropriate state and federal law, and applicable DES rules.

2208 ALTCS Grievance Process

<u>State Only</u>

A member or his/her responsible person may have a complaint regarding an issue unrelated to a Notice of Intended Action, such as a quality of care issue or problems related to communication or courtesy. Members and their responsible persons will be encouraged to discuss any problems or complaints with the Support Coordinator as soon as they arise. The Support Coordinator is responsible for reviewing and investigating complaints and attempting to resolve them informally before they reach the grievance stage. The Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution. If needed, the DPM or designee may assist in the informal resolution.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or his/her responsible person of the process for filing a grievance in person, by telephone or in writing. The Support Coordinator's responsibilities do not extend to preparing the document for the member or the responsible person.

ALTCS Members

The Support Coordinator must document the member's complaint, the Support Coordinator's attempts to resolve the complaint and the fact that the member or his/her responsible person was advised of his/her right to file a grievance and the process for doing so. This documentation should be included in the case notes.

The Division will acknowledge receipt of a grievance orally or in writing. Receipt of grievances will be recorded in the Consumer Resolution Tracking System.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will provide written or oral notice of the grievance decision within 90 calendar days after the Division receives the grievance and will record all results in the Consumer Resolution Tracking System.

2209 ALTCS Notice of Action

Reasons for Use

A Support Coordinator/designee or health plan representative must issue a written Notice of Action to any member/responsible person or authorized legal representative who receives services from the Division when the member or responsible person is not in agreement to an action that results in a requested service not being authorized in the amount, duration or scope which was ordered/requested.

Standard Request

A Support Coordinator/designee or health plan representative will issue a written Notice of Action within 14 calendar days of the request for authorization of a service for a standard request to reduce, suspend, or terminate an authorized service.

Expedited Request

The Division will expedite a request if it is determined that taking the time for a standard request could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. In these circumstances, the decision must be made within 3 working days from the date of receipt of a service request, with a possible extension of up to an additional 14 calendar days if the criteria for an extension are met.

A Notice of Action will be issued within 3 working days for denial of a service request in which an expedited decision was requested. If a service requested is denied after a Notice of Extension was issued, a Notice of Action will be issued.

If a service request does not seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the expedited request may be downgraded to a standard request. When an expedited request is denied, the Division will promptly contact the member/responsible person orally to advise him/her of the denial to expedite the request. The Division will follow the oral notification with written notice of denial no later than 2 calendar days to the member/responsible person. If the member/responsible person disagree, he/she is allowed to submit additional documentation to support the expedited request.

Notice of Extension

A Notice of Extension may be issued for up to 14 additional days if the Division requires further information to make a decision and it is in the member's best interest. When additional information is not received within the timeframes allowed, the service request will be denied.

Format

The notice must be issued on Division or health plan letterhead, written in an easily understood manner, and available in alternate formats. The notice must include the following information:

A. the name and address of the responsible person;

B. the date that the notice is mailed;

C. the name of the member affected by this action;

D. the action that has been taken or intends to be taken;

E. the effective date of the action. A Notice for a previously authorized service must be sent at least 10 days before the date of the proposed termination, suspension, or reduction;

F. the reason for the action;

G. what the member/ responsible person can do if he/she does not agree with this action;

H. how to request an expedited resolution of the appeal;

I. the circumstances under which services can be continued pending resolution of the appeal; and,

J. the signature of the person authorized to make the decision regarding the determinations noted previously.

2210 ALTCS Appeal Process

Filing an Appeal

When a Notice of Action is given by the Division or health plan representative with whom the member/responsible person does not agree, he/she may file an appeal. An authorized representative, including a service provider, may file an appeal on the member's behalf, with written consent from the member/responsible person. The Division will not take punitive action against a service provider who requests a resolution of the appeal or who supports the member's request for a resolution of the appeal.

The member/responsible person/authorized representative must file the appeal either orally or in writing with the Office of Compliance and Review (OCR) within 60 calendar days after the date of the Notice of Action. OCR will acknowledge receipt of the appeal in writing within 5 calendar days.

The Division will assist the member/responsible person with the completion of forms and other procedural steps, upon request. The member/responsible person/authorized representative may present information to the Division at any time during the appeal process. The member/responsible person may review the member's records and other documents considered before and during the appeal process, not protected from disclosure by law.

Appeal Resolution Timeframe

The Division will respond to the standard appeal and mail the written Notice of Appeal Resolution to the member/responsible person/authorized representative within thirty (30) calendar days after the date the Division receives the appeal. The Division will extend the 30-day time frame up to an additional 14 calendar days

upon request by the member/responsible person. The Division may request a 14 calendar day extension of the 30-day time-frame if additional information is needed and the extension is in the best interest of the member. The Office of Compliance and Review (OCR) will provide the member/ responsible person written notice of the reason for the decision to extend the 30-day time frame.

Expedited Appeals

The member/responsible person/authorized representative may request an expedited resolution of the appeal. The Division will conduct an expedited appeal if it is determined that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The Division will conduct an expedited appeal if a request is received directly from a health care provider, with written authorization from the member/responsible person, and the health care provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function.

If the request for an expedited appeal is denied, OCR will promptly contact the member/responsible person orally to advise him/her of the denial. OCR will send written notice of the denial no later than 2 calendar days to the member/responsible person. If a request for an expedited appeal is denied, the Division will resolve the appeal no later than 30 calendar days after the day the Division receives the appeal.

If the request for an expedited appeal is granted, the Division will adjudicate the appeal and mail the written Notice of Appeal Resolution to the member/responsible person/authorized representative within 3 working days after the day the Division receives the request for an expedited appeal. The Division will extend the 3-day time frame up to an additional 14 calendar days upon request by the member/ responsible person. The Division may request a 14 calendar day extension of the 3-day time frame if additional information is needed and the extension is in the best interest of the member. OCR will provide the member/responsible person written notice of the reason for the decision to extend the 3-day time frame.

Appeal Decisions and Timeframes

The Division will ensure that the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will render a written Notice of Appeal Resolution to the member/responsible person no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the

resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or 3 working days for an expedited, the member may consider the appeal denied.

If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. the member's right to request a fair hearing and how to do so;

B. in cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;

C. the factual and legal basis of the decision; and

D. the member/responsible person's liability for the cost of the continued services if AHCCCS upholds the DES/DDD decision.

A.A.C. R9-34-209 through
A.A.C. R9-34-216

2211 ALTCS Fair Hearing Process

When a Notice of Appeal Resolution is rendered by the Division with which the member or his/her responsible person does not agree, he/she may file a request for a fair hearing by the Office of Administrative Hearings (OAH). The fair hearing request must be filed in writing and received by OCR no later than thirty (30) calendar days after receipt of the Notice of Appeal Resolution.

The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

Once the hearing request is filed, OCR staff will prepare a duplicate file for submission to the Arizona Health Care Cost Containment System (AHCCCS) along with the hearing request. The OCR staff will submit the file to AHCCCS within five (5) days. This file will include copies of the Notice of Action, request for fair hearing, investigative materials and the decision letter.

The hearing will be scheduled by AHCCCS and the member or his/her responsible person will be notified of the date and time of the hearing in writing. The member and/or responsible person including any legal representative, an Assistant Attorney General, and a Division representative will meet with an Administrative Law Judge (ALJ). This hearing is formal and the rules of evidence may not apply.

Based on the information gathered by the ALJ through testimony, presentation of evidence and the record supplied by OCR, the ALJ will prepare written findings of fact and conclusions of law, and render a recommended decision to the AHCCCS Director. The AHCCCS Director will then issue his/her decision in writing and notify any party adversely affected of the right to request a rehearing or review. If it is decided that a review will not be petitioned, the OCR will arrange with the appropriate Division staff and /or contracted health plan staff to authorize and provide the service as expeditiously as possible.

A petition for rehearing or review, if requested, must be made to the AHCCCS Office of Administrative Legal Services (OALS) no later than thirty (30) calendar days after the date of the AHCCCS Director's decision. The petition must completely explain the grounds on which the rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The rehearing will be decided by the AHCCCS Director or designee and a final written decision on the matter will be issued.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

2212 Claim Disputes

Claim Dispute Process

A Division representative or health plan representative will provide written notice advising the service provider of a denial of claim payment and the reason for denial. The notice may be included in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the Division or a Division subcontracted health plan.

When a notice is given by the Division or a Division subcontracted health plan with which the service provider does not agree, the service provider may file a claim dispute. A claim dispute will be accepted by the Division or the Division subcontracted health plan only if the dispute involves a payment of a claim, denial of a claim, an imposition of a sanction or reinsurance.

The service provider must file the claim dispute in writing with either the Division or

the Division subcontracted health plan. The claim dispute must be filed within 12 months after the date(s) of service, within 12 months after the date that the member's eligibility is posted or within 60 days after the date of the denial of a timely claim submission.

If the service provider submits the claim dispute directly to the Division subcontracted health plan, the Division subcontracted health plan will forward a copy of the claim dispute to the Division upon receipt. The Division or the Division subcontracted health plan will send the service provider a written notice acknowledging receipt of the claim dispute within 5 working days from the date the claim dispute is received. The Division or Division subcontracted health plan will advise the service provider that any additional information the service provider wishes to submit to the Division for consideration must be done so in 10 calendar days.

OCR staff may contact the service provider and the Division subcontracted health plan to obtain additional information. Subcontracted health plans are required to provide all information related to their recommendation to deny or approve the claim dispute to OCR no later than 10 days after the subcontracted health plan receives the claim dispute. Relevant policies will be reviewed and Central Office staff will be consulted as necessary.

Once the fact-finding is complete, a written Notice of Decision will be rendered to the service provider within thirty (30) calendar days of receipt of the services provider's claim dispute unless the provider and the contractor agree to a longer period. The Notice of Decision will include:

A. the date of the decision;

B. the factual and legal basis for the decision; and

C the service provider's right to request a fair hearing and how to do so.

A.R.S. §36-2903.01.8.4
A.R.S. §41.1 092
A.A.C R9-34-402 through A.A.C. R9-34-405

State Fair Hearings for Claim Disputes

When a service provider does not agree with a Notice of Decision by the Division on a claim dispute, the service provider may file a request for a fair hearing by the Department of Economic Security (DES) Appellate Services Administration/Long Term Care Services. The request for fair hearing must be made in writing and received by the OCR no later than thirty (30) calendar days after receipt of the Notice of Decision. The request should be sent to:

DES/DDD
Office of Compliance and Review

3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

Once the hearing request is made, OCR staff will prepare a duplicate file along with the hearing request for submission to the DES Appellate Services Administration/Long Term Care and the Attorney General's Office. This file will include copies of the claim dispute, investigative materials and the Notice of Decision.

The hearing will be scheduled by a DES Appellate Services Administration/Long Term Care representative, and the service provider will receive written notification of the date and time. The DES Appellate Services Administration/Long Term Care representative will also notify the Attorney General's Office and OCR of the scheduled hearing.

At the hearing, the service provider, a DES/DDD representative, and an Assistant Attorney General will meet with a DES Appellate Services Administration/Long Term Care Hearing Officer. The rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence and other records supplied by OCR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision. The DES Appellate Services Administration/Long Term Care representative will forward a copy of the decision to the AHCCCS Office of Administrative Legal Services, the service provider, DES/DDD and the Attorney General's Office.

Petition for rehearing or review, if requested must be made to the AHCCCS Office of Administrative Legal Services no later than 30 calendar days after the date of the DES Appellate Services Administration/Long Term Care Administrative Law Judge. The petition must completely explain the grounds on which rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the Division decision, the Division will confer with the Attorney General's Office to determine if a request for review will be petitioned to the AHCCCS Director. If it is decided that a review will not be petitioned, the OCR will arrange with the appropriate DES/DDD staff and/or contracted health plan staff to authorize and make payment for the services as expeditiously as possible.

If the service provider is still not satisfied with the decision, the service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

Overturned or Reversed Claim Disputes

The Division or its Subcontractors shall reprocess and pay overturned or reversed claim disputes, within 15 business days of the date of the Decision. The Division or its Subcontractors will make payments in a manner consistent with the Decision.

2213 Contact with Attorneys or Their Staff

The member/responsible person have a right to have anyone present they wish including an attorney or his/her staff and may tape record a meeting. The Division may have their staff present at a meeting and may tape record a meeting.

2214 Conducting All Meetings

To provide defined objectives and to allow for adequate meeting facilities complete the following:

A. clarify the purpose of the meeting;

B. check with the member/responsible person as to how many people they will have in attendance so adequate space will be provided and clarify with the family the names and titles of those attending from the Division; and

C. schedule space appropriate for the number of people in attendance.

Tape Recording Meetings

Unless there are either pending grievances or legal actions, there is no prohibition for members/responsible persons to tape record Individual Support Plan (ISP) meetings. Canceling a meeting for this reason is not acceptable.

Requests for Member Information

In order to ensure uniformity and conformity, all requests for member information must be cleared through the OCR. Situations include, but are not limited to:

A. any circumstance where staff may deem it necessary to initiate contact with an attorney or his/her staff; or

B. any request for member records or communication regarding a member's services unless prior authorized by the OCR.

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2300 PROGRAM OVERSIGHT

2301 Overview

This chapter provides a description of Quality Management and Oversight that includes internal oversight, oversight by external entities and Division oversight findings. All entities with oversight responsibilities have some degree of responsibility for Quality Management.

2302 Quality Management

The purpose of Quality Management is to monitor and assure the quality of all care and services provided to individuals through a coordinated, comprehensive, and continuous effort. The goals of Quality Management include:

A. Ensuring services are available, accessible, timely, safe, supportive, and appropriate.

B. Providing ongoing, objective, and systematic measurement, analysis, and trending to facilitate performance improvement efforts.

C. Oversight for determining quality, efficiency and effectiveness of service delivery.

Division employees are responsible for internal oversight of the following Quality Management activities: ensuring providers are compliant with requirements of external entities; providing oversight of Support Coordination; providing oversight of the Division's contracted Health Plans, and oversight of a variety of services, and settings such as:

A. Assisted living facilities

B. Individual's home (not contracted with the Division)

C. Day programs (adult and child)

D. Employment programs

E. Nursing facilities

F. Provider's home

G. Residential settings (group homes, Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID), developmental homes, etc.)

The following links provide additional information regarding program oversight:

42 CFR 438.66

A.R.S. §36-550, A.R.S. §36-595 et seq.

A.A.C. R6-6; A.A.C R9-28

AHCCCS Policy and Procedure Manual

A.A.C. R9-33
Arizona Department of Health Services

A.A.C. R6-18
Arizona Department of Economic Security (DES), Office of Licensing, Certification and Regulation (OLCR)

2303 Internal Oversight

2303.1 Monitoring

The Division's program and contract monitoring activities provide oversight of services around a set of minimum expectations as documented in statute, rule, and contract. The Division's Program Monitors review all residential settings as required for programmatic and contractual compliance as well as compliance with licensing and certification requirements. Additional monitoring of services may occur depending on Division requirements.

2303.2 Continued Stay Reviews

Continued Stay Reviews ensure the appropriateness and necessity of an ICF/ID level of care through reviews of health and programmatic records. The review also assesses the quality of care and assists in discharge planning.

Quality Management staff must review each individual within six (6) months of admission and at least every six (6) months thereafter. Reviewers evaluate the physician's certificate of need for care, medical evaluations, the plan of care and the facility's Utilization Control Plan in relation to the individual's community integration and placement in the least restrictive environment.

2303.3 Program Operations and Business Operations

Prior to receiving a contract, Division staff will ensure applicants have completed all the necessary steps, and qualify as a provider for the Division. Division employees at the District and Central Office are required to provide oversight of contracted providers to ensure contract compliance.

2303.4 Support Coordination

Support Coordination serves as the first level of oversight to ensure Division funded settings and services are meeting the individual's needs. This oversight can take place during a review and/or annual planning meeting and includes an assessment of the placement and/or provider's ability to meet the individual's needs. On-site reviews shall be conducted while the individual is present.

Support Coordination is responsible for reporting any concerns regarding the setting or the provider's ability to meet individual's needs using the incident reporting system. See Chapter 2100 for further details.

Support Coordination is also responsible for ensuring the implementation of the ALTCS program as described in the AHCCCS Medical Policy Manual. This includes oversight of all services in all settings.

2303.5 Health Care Services

Health Care Services serves as the first level of oversight to ensure contracted health plans comply with their contract.

In addition to the reviews completed by the Support Coordinator, Health Care Services nurses complete utilization/concurrent reviews to ensure

individuals are receiving the appropriate level of nursing care. This oversight can be provided in all settings.

2303.6 **ALTCS Administrator/Specialists**

The ALTCS Administrator oversees the entire ALTCS program including oversight of the ALTCS Specialists/designees who audit case files to monitor support coordination compliance with the ALTCS program.

The Division monitors implementation of the Arizona Long Term Care System (ALTCS) and Targeted Support Coordination (TSC) programs through the use of specific audit tools. Data gathered is analyzed to identify Support Coordination system issues and corrective action plans are developed as appropriate.

ALTCS

A. An ALTCS audit monitors completion of timely planning meetings by a review of case files. Documentation in the case file must establish the following:

1. The member's presence and participation with support as needed in the development of the planning document.

2. The meeting occurred at the member's home unless documentation indicates the member/responsible person has chosen an alternate location.[i]

3. An acceptable reason when the planning meeting occurs after the due date.

B. The *ALTCS On-Site and Timeliness Audit* are used to monitor timeliness of planning meetings. To achieve timeliness, a planning meeting must have occurred:

1. Within the required interval based on a comparison of the date of the most current and the previous review (prior timeliness); and,

2. On the date of the audit, all planning meetings must be current. (Current timeliness).

The Division completes this audit on 100% of the ALTCS cases for 10% of Support Coordinators per District, each quarter. Of the cases audited, 90% must demonstrate timely planning meetings for both current and prior timeliness. In addition, each District must meet the 90% requirement for cases audited in that District each quarter.

C. The *Support Coordinator ALTCS Audit* is used to monitor the Division's compliance with its policies and procedures and the AHCCCS Medical Policy Manual (AMPM.) Quarterly, the District must complete a minimum of two *Support Coordinator ALTCS* audits for every Support Coordinator position allocated, including vacant positions. For each audit question, 90% of the responses must demonstrate compliance. In addition, each District must meet the 90% compliance requirement for each audit question.

TSC

A. The TSC audits monitor completion of a timely planning meeting through a review of documentation contained in a member's file Documentation must establish the following:

1. The planning meeting was held at the frequency requested by the member/responsible person using the contact type requested; and,

2. An acceptable reason if the planning meeting occurred after the due date.

B. The Targeted Timeliness Audit is used to monitor completion of a timely planning meeting through a review of documentation contained in a member's file. Documentation must establish the following:

1. At least annually, the type and frequency of contact chosen.

2. When the member receives a service that has a "mandated minimum review cycle" requirement, the chosen contact type and frequency do not exceed the "mandated minimum review cycle."

3. The planning meeting is within requested/required intervals based on a comparison of the date of the most current and the previous review (prior timeliness).

4. The most current planning meeting is within the required interval when compared to the date of the audit (current timeliness).

The Division completes audits on 100% of the Targeted cases for 10% of Support Coordinators per District, each quarter. Of the cases audited, 90% must demonstrate timely planning meetings for both current and prior timeliness. In addition, each District must meet the 90% requirement for cases audited in that District each quarter.

C. The Targeted Support Coordination Audit is used to monitor the Division's compliance with its policies and procedures and the AHCCCS Medical Policy Manual (AMPM). Quarterly, each District completes audits on 10% of their Targeted Support Coordination cases. For each audit question, 90% of the responses must demonstrate compliance. In addition, each District must meet the 90% compliance requirement for each audit question.

2303.7 **Other**

Additional Division employees are responsible for oversight activities such as tracking, trending and reporting issues related to Quality Management.

Additional oversight of Support Coordination occurs at the District and Central Office level.

2304 External Oversight

2304.1 **Licensing/Certification**

For settings that require licensing and/or certification, the entities that provide the license and/or certification also have oversight responsibilities. Entities responsible for oversight include:

A. U.S. Department of Labor

B. Arizona Department of Health Services (DHS)

C. Arizona DHS, Division of Behavioral Health Services (DBHS)

D. Arizona DHS, Division of Licensing Services, Office of Long-Term Care Licensing

E. Arizona Department of Economic Security (DES), Office of Licensing, Certification and Regulation (OLCR)

2304.2 **Arizona Health Care Cost Containment System (AHCCCS)**

AHCCCS, as the Single State Medicaid agency, has the authority to inspect Arizona Long Term Care System (ALTCS) funded settings at any time. The purpose of AHCCCS oversight is to ensure compliance with the standards set forth in the AHCCCS Medical Policy Manual (AMPM). The Division, as an ALTCS program contractor, is required to ensure that all ALTCS eligible individuals are receiving services as medically needed. This process typically involves review of support coordination functions as they relate to the Planning Document. AHCCCS may or may not actually visit the site during the review.

2304.3 **Advocacy**

Advocacy agencies have the authority to review residential settings in the community at reasonable times. This authority was granted because of the Arizona Training Program Coolidge lawsuit (*Griswold vs. Riley*) and is noted in Arizona Revised Statutes. This includes the Developmental Disabilities Advisory Council.

2304.4 **Financial Audit**

All agencies with a contract are subject to the programmatic and fiscal monitoring requirements of the Department to ensure accountability of the delivery of all goods and services. Specific requirements are delineated in the provider's contract.

2305 Division Oversight Findings

When deficiencies are identified, the scope and severity of the deficiencies as well as the oversight activity, will determine the next steps. At a minimum, the Division may request a Corrective Action Plan from the Provider.

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[i] **At least one ISP/review must occur in the individual's home every twelve months.**

Appendix A Attendant Care Supervision Requirements – Age 17 And Under

Appendix B Attendant Care Supervision Requirements – Age 18 And Above

Appendix C Attendant Care Supervision Documentation Requirements

Appendix D Skilled Nursing Matrix

APPENDIX A

ATTENDANT CARE SUPERVISION REQUIREMENTS – AGE 17 AND UNDER

INITIAL IMPLEMENTATION: March 1, 2013

Overview

This information clarifies the criteria to meet medical necessity for **general supervision** for children age 17 and under as part of the Attendant Care service.

Age 17 and under: A child must meet the criteria indicated in one of the four categories outlined below:

1. Unsafe Behaviors

   A. Documentation of behaviors placing the child at risk of injury to self or others, **AND**

   B. Documentation that the child is receiving or pursuing services through a behavioral health agency/professional;

   OR

   A. Documentation of behaviors placing the child at risk of injury to self or others, **AND**

   B. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

2. Medical

   Documentation is required from a medical professional describing a severe medical need or physical condition that would place the child at risk if left alone.

3. Confused/Disoriented

   Documentation indicating a loss of skills (e.g., due to accident or injury) that are unlikely to be regained.

4. Wandering risk (age 13 - 17 only)

   A. Documentation of the child leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals, **AND**

   B. The youth is at risk to self or others when alone in the community or may be unable to return safely.

When a child age 17 and under meets one of the criteria outlined above, **general supervision** is then based on age criteria. The requirements outlined below may be waived with DPM approval.

For children age 12 and under **general supervision** may be provided when **all** of the following are met:

1. The child cannot attend a typical day care center because
   A. The child's health and safety would be at risk, **OR**
   B. The health and safety of others will be at risk, **OR**
   C. A fundamental alteration of a day care center would be required. This requires documentation from the day care center.

   AND

2. Child care in a private home or a before/after school program offered by the school/local city or county is not available or cannot meet the child's needs.

   AND

3. The parent, guardian, or other adult is not in the home.

   AND

4. Division funded summer or after school program is not available or cannot meet the child's needs. (Only applies to age 3 and above.)

For children age 13- 17 **general supervision** may be provided when **all** of the following are met:

1. A Division funded program is not available or has been considered and is not appropriate.

   AND

2. The youth receives enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP).

   AND

3. The parent, guardian or other adult is not in the home.

   AND

4. The youth has received, is receiving or will receive Habilitation to minimize the need for supervision in the future, if a wandering risk or has unsafe behaviors.

APPENDIX B

ATTENDANT CARE SUPERVISION REQUIREMENTS – AGE 18 AND ABOVE
INITIAL IMPLEMENTATION: MARCH 1, 2013

Overview

This information clarifies the criteria to qualify for general supervision for adults age 18 and above as part of the Attendant Care service.

Age 18 and above: An adult must meet one of the criteria outlined below:

1. Unsafe behaviors

   A. Documentation that behaviors place the adult at risk of injury to self or others, **AND**

   B. Documentation that the person is receiving or pursuing services through a behavioral health agency/professional

   OR

   C. Documentation that behaviors placing the adult at risk of injury to self or others. **AND**

   D. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

2. Medical

   Documentation is required from a medical professional describing a severe medical need or physical condition that would place the adult at risk if left alone.

3. Wandering risk

   A. Documentation of the adult leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals,

   AND

   B. The adult is at risk when alone in the community and may be unable to return safely.

4. Confused/disoriented

A. Documentation of the presence of confusion or disorientation (prior to being diagnosed with dementia), **OR**

B. Documentation indicating a loss of skills (e.g., due to accident or injury) and are unlikely to be regained.

5. Unable to call for help even with a lifeline

Documentation is available in the member's file that the adult is unable to use a telephone or press a button to alert the lifeline system.

When an adult 18 years of age and older meets one of the criteria outlined above, supervision is then based on the following age criteria. The requirements outlined below may be waived with DPM approval.

For adults age 18 and above supervision may be provided when the first criteria and the others (if applicable) are met:

1. A Division funded employment/day program is not available or has been considered and not appropriate.
2. If still in school, the adult must receive enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP).
3. If appropriate, an adult who has an identified wandering risk or has unsafe behaviors must have received, is receiving or will receive habilitation to minimize the need for supervision in the future.

APPENDIX C

ATTENDANT CARE SUPERVISION DOCUMENTATION REQUIREMENTS

INITIAL IMPLEMENTATION: MARCH 1, 2013

Overview

Documents that may provide justification of medical necessity for supervision include but are not limited to the following:

1. Individual Support Plan
2. Individualized Education Program (IEP)
3. Multi-Disciplinary Education Team (MET)
4. Medical Documentation
5. Psychiatric/Psychological Evaluation
6. Clinical Notes
7. Incident Reports
8. Pre-Admission Screening (PAS)
9. Police Reports
10. Inventory for Client and Agency Planning (ICAP)
11. Adaptive Mini-Mental (Pre-Dementia Screening Tool)

APPENDIX D

SKILLED NURSING MATRIX
REVISION DATE: January 31, 2014
INITIAL IMPLEMENTATION DATE: August 30, 2013

Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Anticoagulant Therapy	Medications used to make the blood less likely to clot or form scabs	Assessment and monitoring for unstable anticoagulant therapy
Apical Pulse Check	Use of a stethoscope to listen to the heart beat at the level of the heart	Listening to heart beat on chest for full minute
Bi-level positive airway pressure (BiPAP)	A machine that helps an individual breathe	Turning on and off, changing settings, respiratory assessment, circuit changes
Blood Pressure Checks	Assessment of Blood Pressure	Blood pressure monitoring and treatment when it is too high or too low
Chest percussion therapy (CPT)	Therapy by clapping on the chest either manually or with a machine	Application of the therapy techniques and assessment of effectiveness, respiratory assessment
Complex wound care	Assessment and treatment of wound	Assessment and treatment of wound, including but not limited to wound cleaning and bandage changes

Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Complex/Unstable Seizure Disorder	A change in the way a person acts or moves that is not normal due to a brain problem.	Neurological assessment and emergency medical intervention for unstable seizure activity.
Coughalator/cough assist device	A machine that causes the member to cough	Application of machine and assessment of effectiveness of machine; respiratory assessment
Dialysis (occurring at home)	Cleaning of blood through a machine or tube	Assessment and monitoring; starting and stopping of the treatment
Extremity edema checks when ordered by a physician	Assessment of extra fluid buildup in the extremities	Checking for fluid in the legs or arms; assessment
GJ Tube Gastrostomy/Jejunostomy	A feeding tube into the gastric (stomach) continuing to the Jejunum (small intestine)	Insertion of liquid food, water and/or medication into the tube
Injections	Medication given with a needle	Administering medication with a needle
Insulin Administration	Medications given with a needle to treat diabetes	Administering insulin with a needle
Intermittent partial pressure breathing (IPPB)	A machine to assist with breathing all the time	Monitoring effectiveness of machine, changing settings on machine as ordered, respiratory assessment and intervention, circuit changes

Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Intravenous (IV) Therapy (For individuals living at home)	Administration of fluids and medications into the venous blood supply	Administering medications through an IV into the blood and any dressing changes needed
J-Tube (Jejunum-tube)	A feeding tube through the Jejunum (small intestine)	Insertion of liquid food, water and/or medication into the tube
Nasogastric enteral feeding (NG tube)	Liquid food and water fed through a tube from the nose into the stomach	Checking tube placement; start feeding; stop feeding.
Nephrostomy	Surgically placed tubes used to flush fluid to clean the kidney(s)	Flushing fluid into tubes that cleans the kidney(s)
Ostomy irrigation	Flushing of an opening into the body with fluid	Cleaning out the organ with fluid
Oxygen Titration	Giving oxygen at an amount that changes dependent on the person's blood oxygen levels	Changing the level of oxygen administration based on pulse oximeter readings
Postural drainage	A treatment to clear the lungs by moving the body in a downward position	Assessment and draining the lungs of fluids
Pressure Ulcer	An area of the skin that breaks down when something keeps rubbing or pressing against the skin.	Assessment and monitoring of the care and healing of the pressure ulcer.
Pulse Oximeter	A machine that measures oxygen levels in the blood	Monitoring the amount of oxygen in the body

Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Sleep Apnea	The temporary stoppage of breathing during sleep	BiPAP machine or Vent used to treat the condition, respiratory assessment (the assessment for Apneic episodes)
Small Volume Nebulizer (SVN) (varied or unscheduled)	Medications given at varied times using a small-volume nebulizer, a device that holds liquid medicine which is then turned into a fine mist.	Assessment of needed time for medicated breathing treatments
Sputum sample	Chest fluid sample test	Collection of fluid from chest
Suctioning (tracheal or deep through the nose or mouth)	Use of a tube to suction out the throat and lungs through a tube in the throat or deep into the mouth	Inserting tube into the throat and/or lungs through the mouth or the nose to get fluid out
Tracheotomy	A surgery to make an opening through the neck into the windpipe to allow for breathing	All tracheotomy management and care
Urinary Catheter	A tube into the bladder to drain out urine	Insertion of a tube into the bladder to drain out urine
Ventilator	A machine that provides breathing support continuously	All ventilator management and care