

**State of California
Department of Health Services**

**REQUEST FOR A RENEWAL APPLICATION
HOME AND COMMUNITY-BASED SERVICES WAIVER
for the
DEVELOPMENTALLY DISABLED
CONTROL NUMBER 0336
OCTOBER 2006 – SEPTEMBER 2011**

**To the Secretary of the
United States Department of Health and Human Services
In accordance with Section 1915(c) of the Social Security Act**

Version 3.3		Location in 2006 Waiver Renewal Document
1. Request Information A. State	The State of <u>California</u> requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915 (c) of the Social Security Act (the Act).	Waiver Request Page 1, #1
B. Waiver Title	Home and Community Based Services Waiver for the Developmentally Disabled	Optional, Cover Letter
C. Type of Request	Select only one: <input type="checkbox"/> New waiver (3 years) <input type="checkbox"/> New waiver to replace waiver # _____ (3 years); or <input checked="" type="checkbox"/> Renewal of Waiver (5 Years) <input type="checkbox"/> Amendment to Waiver #	Waiver Request Page 1, #1.b
D. Type of Waiver	Check one: <input type="checkbox"/> Model waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time. <input checked="" type="checkbox"/> Regular waiver, as provided in 42 CFR §441.305(a)	Waiver Request Page 1, #1.a.
E.1 Proposed Effective Date	<input checked="" type="checkbox"/> The State has indicated appropriate effective dates. <i>Note: In order to facilitate data reporting, new waivers should be structured with effective dates on the first day of the month or the beginning of a calendar quarter. For renewal applications or new waivers that replace existing waivers, the proposed effective date should be the day after the existing waiver expires.</i>	Waiver Request Page 10, #19 <u>10-1-2006 – 9-30-2011</u>
E.2 Approved Effective Date		CMS use only

Version 3.3		Location in 2006 Waiver Renewal Document
<p>1. Request Information (continued)</p> <p>F. Level of Care</p>	<p>This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (<i>check each that applies</i>):</p> <p><input type="checkbox"/> Hospital</p> <p style="padding-left: 20px;"><input type="checkbox"/> Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160</p> <p><input type="checkbox"/> Nursing facility</p> <p style="padding-left: 20px;"><input type="checkbox"/> As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140</p> <p><input checked="" type="checkbox"/> Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:</p>	<p>Waiver Request Page 1, #2.b.</p>
<p>G. Concurrent Operations with Other Programs</p>	<p>The State has indicated that this waiver operates concurrently with another program(s) approved under the following authorities:</p> <p><input type="checkbox"/> Services are furnished under 1915(a) of the Act and described in Worksheet I.</p> <p><input type="checkbox"/> Services are furnished under 1915(b) of the Act. The State has provided its title and indicated the waiver authorities the waiver operates under.</p> <p><input type="checkbox"/> A program under 1115 of the Act.</p>	<p>Not applicable</p>

Version 3.3	Location in 2006 Waiver Renewal Document
<p>2. Brief Waiver Description. In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.</p>	Attachment to Waiver Request
<p>3. Components of the Waiver Request <i>Item 3-E must be completed.</i></p>	
<p>A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.</p>	Appendix A
<p>B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.</p>	Waiver Request Appendix C Appendix D-1, D-2, D-3, and D-4 Appendix G
<p>C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.</p>	Waiver Request Appendix B Appendix G – Factor C, Page G-2
<p>D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).</p>	Appendix A Appendix D-4 Appendix E
<p>E. Participant-Direction of Services. When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (<i>Select one</i>):</p> <p><input checked="" type="checkbox"/> The waiver provides for participant direction of services. <i>Appendix E is required.</i></p> <p><input type="checkbox"/> Not applicable. The waiver does not provide for participant direction of services.</p>	Attachment #1 to Appendix A Appendix B Appendix D-2-a Appendix D-4 Attachment #2 to Appendix D-4
<p>F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.</p>	Appendix D
<p>G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.</p>	Appendix A Appendix B Appendix H
<p>H. Quality Management Strategy. Appendix H contains the Quality Management Strategy for this waiver.</p>	Appendix H

Version 3.3	Location in 2006 Waiver Renewal Document
<p>I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.</p>	<p>Waiver Request Appendix A Appendix B Appendix F Appendix G Appendix H</p>
<p>J. Cost-Neutrality Demonstration. Appendix J contains the State’s demonstration that the waiver is cost-neutral.</p>	<p>Appendix G</p>



DEPARTMENT OF HEALTH & HUMAN SERVICES
Ref: MCD-WCG-RMS

Centers for Medicare & Medicaid Services
 San Francisco Regional Office
 75 Hawthorne St., Suite 408
 San Francisco, CA 94105

AUG 29 2006

Stan Rosenstein, Deputy Director
 Medical Care Services
 Department of Human Services
 MS 4000
 P.O. Box 942732
 Sacramento, CA 94234-7320

Dear Mr. Rosenstein:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to renew California's Medicaid Home and Community-Based Services (HCBS) waiver for individuals with developmental disabilities/mental retardation (DD/MR) as authorized under Section 1915(c) of the Social Security Act. This renewal action has been assigned CMS control number 0336.90.R1. This waiver program provides HCBS as an alternative to institutional care for persons eligible for ICF/MR placement. The effective date of this renewal is October 1, 2006.

This renewal requests permission for the State to enhance the waiver's quality management system to include a more comprehensive and representative sampling system, more complete and timely special incident reporting, more insightful risk management analysis, and more comprehensive fiscal oversight of waiver providers. Also, the definition of several waiver services has been modified to provide participants with more care options designed to meet their individual needs and preferences. Due to these changes in the waiver program service coverage, projected inflation factors, and anticipated enrollment increases of about 25,000 persons over the course of the waiver renewal period, estimates of Factor D or total waiver expenses eligible for FFP will be increased by approximately \$100 million over the renewal period October 1, 2006 – September 30, 2011 inclusive.

This approval is subject to your agreement to provide services for no more individuals than the number listed in column "C" below:

<u>WAIVER YEAR</u>	<u>FACTOR C</u>	<u>FACTOR D</u>	<u>TOTAL</u>
Oct. 1, 2006 – Sept. 30, 2007	75,000	x \$21,276	= \$1,595,707,254
Oct. 1, 2007 – Sept. 30, 2008	80,000	x \$21,632	= \$1,730,527,290
Oct. 1, 2008 – Sept. 30, 2009	85,000	x \$22,101	= \$1,878,584,992
Oct. 1, 2009 – Sept. 30, 2010	90,000	x \$22,608	= \$2,034,756,390
Oct. 1, 2010 – Sept. 30, 2011	95,000	x \$23,130	= \$2,197,321,894

Page 2 - Stan Rosenstein

The totals shown for waiver years 1 through 5 are adjusted slightly to agree with the State estimates shown in Appendix G-2 of the renewal.

We appreciate the cooperation provided by you and your staff. If you have any questions, please contact Rick Spector at (415) 744-3592.

Sincerely,



Linda Minamoto
Associate Regional Administrator
Division of Medicaid & Children's Health

cc: Gail Arden, Director, DEHPG, CMSO
Debra Baumert, CMS, Region IX
Ellen Blackburn, DEHPG, CMSO
Clifford Allenby, Director, DDS
Tolu Oladmeiji, CMS, Region IX
Barbara Lemus, Chief, Waiver Analysis Branch, MCPD
Dale Sorbello, Deputy Director, Community Services Division, DDS
Greg Saul, Chief, Federal Programs Operations Section, DDS
Rosa King, Chief, HCBS Waiver Unit, Waiver Analysis Branch, MCPD

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APPENDIX H: HCBS WAIVER QUALITY MANAGEMENT STRATEGY

SUMMARY OF AMENDMENTS DDS HCBS WAIVER Control #0336

The following are the summary of changes and respective pages to the Waiver Renewal packet. New and/or amended language is shown as **italicized, underlined/strike out, and in bold print**.

WAIVER REQUEST

Page 9: Technical Amendment to change the effective date of the Waiver and to add the State operating agency contact information.

Page 11: New Attachment to Waiver Renewal packet to add Waiver Description.

Appendix A – ADMINISTRATION

Page A-6 and A-8: Technical Amendment to reflect updated sampling methodology.

Page A-9: Technical Amendment to remove the word “Expanded”.

Page A-10: Technical Amendment to correct the word “plan” to “plant”.

Page A-11: Technical Amendment to remove the word “serious” and insert the word “suspected”.

Page A-13: Technical Amendment to change effective date of Interagency agreements between DHS and DDS

Page A-16: Technical Amendment to description of Regional Center Performance Contracts.

Page A-17: Technical Amendment to update description of Risk Management System.

Page A-20: New Attachment to add Title 17, California Code of Regulations Sections

Appendix B – SERVICES AND STANDARDS

Page B-19: Technical Amendment to modify the Adult Residential Care, Adult Foster Care definition.

Page B-24 and B-25: Technical Amendment to remove reference to age limit for Specialized Therapeutic Services.

Page B-49: Technical Amendment to remove Travel Reimbursement as a provider type for Family Training.

Page B-50: Technical Amendment to add Family Teaching Home as a provider type for Adult Residential Care – Adult Foster Home.

Page B-51: Amended to add Adult Residential Facilities for Persons with Special Health Care Needs as a provider type for Assisted Living – DSS Licensed – Special Residential Facility – Adult/Elderly. Also Amended to correct legal reference to Welfare and Institutions Code.

Page B-53: Technical Amendment to add Assistant Behavior Analyst and Psychiatrist as a provider types for Mobile Crisis Intervention.

Page B-57: Technical Amendment to add Assistant Behavior Analyst as a provider type for Behavior Intervention Client/Parent Support Behavior Intervention Training.

Page B-58: Technical Amendment to include the Title 9 regulations reference for certification of Chemical Addiction Counselors.

Page B-77: Technical Amendment to remove Travel Reimbursement as a provider type for Family Training.

Page B-79: Technical Amendment to add Adult Residential Facilities for Persons with Special Health Care Needs, as an example of a DSS Licensed – Specialized Residential Facility – Adult/Elderly.

Page B-87 and B-88: Technical Amendment to strike out the additional provider qualifications for Chemical Addiction Counselor – Specialized Therapeutic Services, as these are covered by reference in Appendix B-2 – Provider Qualifications, page B-58.

Page B-88: This renumbered page (due to the strike out starting on Page B-87) is a Technical Amendment to correct the regulation section for Vouchers (which should be 54355 not 54344).

Page B-89: Technical Amendment to add Attachment to Appendix B-3: Title 17, California Code of Regulations, Section 56075, Family Home Agency.

Appendix E – PLAN OF CARE

Page E-1: Technical Amendment to update description of the Plan of Care development team

Appendix G – FINANCIAL DOCUMENTATION

Page G-1: Amended to show changes to Factors D, D', G, and G'.

Page G-2: Amended to show changes to Unduplicated Individuals for Years 1-5.

Page G-3: Amended to show calculation for Average Length of Stay and Factor D derivation.

Pages G-4 through G-8: Amended to show Unduplicated Recipients, Annual Units/User, Unit Cost and Total for fiscal years 2006/07, 2007/08, 2008/09, 2009/10, and 2010/2011. Also amended to show change to Average Length of Stay for month/client/year.

Page G-9: Amended to show fiscal year upon which estimates were based, current cost of living factor, and regional center caseload increases for years 2, 3, 4, and 5 of the current waiver renewal.

Pages G-10 and G-11: Amended to show Unduplicated Recipients, Annual Units/User, Unit Cost and Total for fiscal years 2006/07, 2007/08, 2008/09, 2009/10, and 2010/2011.

Page G-13: Technical Amendment to update description of the method used to exclude payments for Room and Board.

Page G-15: Amended to show updated estimates for payment of rent and food expenses based on 2006 Fair market Value

Page G-16: Amended to show Mean Rental Costs for 2006.

Page G-17: Amended to show Factor D' does not include the cost of prescription drugs furnished to Medicare/Medicaid dual-eligibles.

Page G-18: Amended to show fiscal year upon which Factor D' was computed.

Page G-19: Amended to show updated Community-Based services acute care calculations: Factor D'.

Page G-20: Amended to show fiscal year upon which Factor G was computed.

Page G-21: Amended to show updated Medicaid recipients and reimbursement projections: Factor G.

Page G-22: Amended to show fiscal year upon which Factor G was computed.

Page G-23: Amended to show updated Institutional long-term acute care calculations: Factor G'.

Page G-24: Amended to show changes to Factors D, D', G, and G'.

Appendix H – HCBS WAIVER QUALITY MANAGEMENT STRATEGY

Pages H-1 through H-23: New Appendix added.

- e. ___ developmentally disabled
- f. X mentally retarded and developmentally disabled
- g. ___ chronically mentally ill
4. A waiver of §1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):
- a. ___ Waiver services are limited to the following age groups (specify):
-
- b. ___ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
-
- c. ___ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. X Other criteria (specify)
- California uses the State's definition of "developmentally disabled" for the target population of this waiver, as defined in the California Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code, §4512(a), as follows:

"Developmental disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include disabling conditions found to be closely related to mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.
 - The following additional criteria are used to limit who will receive services under the waiver.

This waiver will serve developmentally disabled Medi-Cal beneficiaries who, in the absence of this waiver, would otherwise

- k. Specialized medical equipment and supplies
- l. Chore services
- m. Personal Emergency Response Systems
- n. Companion services
- o. Private duty nursing
- p. Family training
- q. Attendant care
- r. Adult Residential Care
 - Adult foster care
 - Assisted living
 - Supported living services
- s. Extended State plan services (specify):
 - Physician services
 - Home health care services
 - Physical therapy services
 - Occupational therapy services
 - Speech, hearing, and language services
 - Prescribed drugs
 - Other (specify)
- t. Other services (specify):
 - Vehicle adaptations
 - Communication aides
 - Crisis intervention
 - Crisis intervention facility services
 - Mobile crisis intervention

- Nutritional consultation
- Behavior Intervention services
- Specialized Therapeutic Services
- Transition/Set Up Expenses

- u. _____ The following services will be provided to individuals with chronic mental illness:
- _____ Day treatment/partial hospitalization
 - _____ Psychosocial rehabilitation
 - _____ Clinic services (whether or not furnished in a facility)
12. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (check all that apply):
- a. When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility)
 - b. _____ Meals furnished as part of a program of adult day health services
 - c. When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides

in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

This will only be done as part of supportive living services.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 3. Assurance that all facilities covered by §1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
 - b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
 - c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.

- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount, and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with the data collection plan designed by CMS.
- i. The agency will assure programmatic and financial accountability, including funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate programmatic and financial records documenting the extent and cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502. All audits will conform with a) generally accepted auditing standards; and b) Government Auditing Standards issued by the Comptroller General of the United States.

21. This document, together with Appendices A through H, and all attachments, constitutes the State's request for a home and community based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure, and certification requirements) will be kept on file at the Medicaid agency.

Signature:

Stan Rosenstein, Deputy Director, Medical Care Services
Department of Health Services
1501 Capitol Avenue, 6th Floor, MS 4000
P. O. Box 942732
Sacramento, CA 94234-7320
(916)440-7800 Fax: (916)440-7805
Email: srosenst@dhs.ca.gov

Attachment to Waiver ApplicationDescription of Waiver

Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private, non-profit corporations known as regional centers. Regional centers, as established by the Lanterman Developmental Disabilities Services Act, provide fixed points of contact in the community for persons with developmental disabilities and their families. Regional centers coordinate and/or provide community-based services to eligible individuals. The regional centers are community-based nonprofit corporations governed by volunteer Boards of Directors that include individuals with developmental disabilities, families, a representative of the vendor community, and other defined community representatives.

Regional centers are funded through contracts with the Department of Developmental Services (DDS). They are responsible for the provision of outreach; intake, assessment, evaluation and diagnostic services; preventive services, and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled. In addition, regional centers are responsible for developing, maintaining, monitoring and funding a wide range of services and supports to implement the individual program plans (IPP) for consumers. The IPPs are developed using a person-centered planning approach. Regional centers also conduct quality assurance activities in the community, and maintain and monitor a wide array of qualified service providers.

Regional centers conduct individualized assessments to establish a consumer's Waiver eligibility; develop, monitor and update consumers' IPPs in response to changing needs; monitor the delivery of services; and ensure the health and safety of HCBS Waiver participants.

DDS ensures, under the oversight of the Department of Health Services, the State Medicaid agency, that the HCBS Waiver is implemented by regional centers in accordance with Medicaid law and the State's approved Waiver application. The HCBS Waiver affords California the flexibility to develop and implement creative, community alternatives to institutions. California's HCBS Waiver services are available to regional center consumers who are Medicaid (Medi-Cal in California) eligible and meet the level-of-care requirements for an intermediate care facility serving individuals with developmental disabilities.

APPENDIX A - ADMINISTRATION**LINE OF AUTHORITY FOR WAIVER OPERATION**

CHECK ONE:

- The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.
- The waiver will be operated by the Department of Developmental Services (DDS), a separate agency of the State, under the supervision of the Department of Health Services (DHS), the Medicaid agency. DHS will exercise administrative discretion in the administration and supervision of the waiver and shall review any DDS waiver-related policies, procedures, rules or regulations for consistency with the waiver, Medicaid statutes and regulations and will approve prior to issuance the DDS Waiver Policy Manual, waiver program advisories, waiver technical letters and such other policies, procedures, rules or regulations that DHS may identify as specific to the HCBS Waiver or any other Medicaid-related issues. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.
- The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

ATTACHMENT #1 TO APPENDIX A
ROLES AND RESPONSIBILITIES

ROLES AND RESPONSIBILITIES

I. DEPARTMENT OF HEALTH SERVICES - MONITORING AND OVERSIGHT

Administration

The California Department of Health Services (DHS) is the Medicaid Single State Agency. DHS has established an Interagency Agreement (IA) with the Department of Developmental Services (DDS) to administer the waiver program. DHS will exercise administrative discretion in the administration and supervision of the waiver and shall review any DDS waiver-related policies, procedures, rules or regulations for consistency with the waiver, Medicaid statutes and regulations and will approve prior to issuance the DDS Waiver Policy Manual, waiver program advisories, waiver technical letters and such other policies, procedures, rules or regulations that DHS may identify as specific to the HCBS Waiver or any other Medicaid-related issues.

DHS will perform the following general administrative functions:

- Ensure technical compliance and correctness of the IA and any related subcontracts;
- Maintain information appropriate to the fiscal and programmatic requirements delineated in the IA;
- Operate and maintain an invoice tracking, payment and reconciliation process;
- Review and approve required reports;
- Review, negotiate and approve amendment requests for the IA; and
- Work jointly with the DHS' Audits and Investigations Division (A&I) to develop documents and guidelines to be used for monitoring fiscal and programmatic aspects of the IA.

Monitoring and Oversight -- Program Services/Health and Welfare

DHS, Medi-Cal Operations Division (MCOD), is assigned the responsibility of development and maintenance of the DHS Monitoring and Oversight Protocol for the DDS Medicaid program's services including health and welfare. DHS-MCOD will work collaboratively with DDS, DHS, and A&I, and independently ensure the waiver program and services are implemented in accordance with Medicaid statute, regulations and waiver requirements. DHS-MCOD carries out this responsibility by:

- Monitoring reviews conducted in accordance with the DHS Oversight Protocol, including but not limited to the following functions:
 1. DDS/DHS collaborative regional center monitoring reviews biennial (10-11 regional centers per year)

2. Follow-up reviews which will be completed when it is necessary to ascertain whether the areas of non-compliance have been corrected. The nature and extent of non-compliance dictates the scope of the follow-up review.
 3. DHS independent focused reviews (announced or unannounced) that are a follow-up review to investigate significant special incident reports, (selection basis could include, but not limited to, gravity of event or unusual nature of circumstances) consumer/advocate complaints or CMS concern/requests for investigation.
 4. Full-scope monitoring reviews which are an activity over and above routine monitoring reviews. It includes other departmental branches in addition to DDS-HCBS Section and DHS-MCOD and is intended to be carried out when: (a) there is a failure of fiscal audit, (b) lack of response to a corrective action plan, (c) when in the course of a monitoring review, DHS or DDS needs assistance from other departmental branches, (d) when DHS elects to conduct a full scale review based on evidence of inadequate case management and/or poor fiscal management by a regional center.
- DHS-MCOD will refer all fiscal integrity issues, identified during the DHS monitoring reviews, to DDS Audits and DHS Audits & Investigations (A&I) for investigation, and to the DDS Federal Programs Operations Section and DHS Medi-Cal Policy Division for information.

The DHS Oversight Protocol for the DDS Medicaid waiver program is intended to delineate performance monitoring, analysis, and evaluation activities to be performed by DHS as the single State agency, in monitoring the DHS/DDS Interagency Agreement, DDS compliance with State and Federal laws and regulations, and DDS adherence to the conditions of the waiver.

Fiscal Oversight

DHS Audits and Investigations Division (A&I) is assigned the responsibility of fiscal oversight for the DDS Home and Community-Based Services (HCBS) Waiver program. DHS A&I will work collaboratively with DDS, DHS-MCOD, and independently to ensure the waiver program and services are implemented in accordance with Medicaid statute, regulations and waiver requirements. DHS A&I responsibilities are to:

- Monitor DDS compliance with fiscal provisions as defined under the Interagency Agreement relative to audits of regional centers.
- Review DDS audit protocol to ensure compliance with the HCBS Waiver.
- Ensure that DDS audits of regional centers are conducted on a biennial basis.

- Ensure that audits conducted by DDS are in accordance with established protocols and meet Generally Accepted Government Auditing Standards requirements.
- Ensure that DDS and regional centers are conducting fiscal reviews of vendors.
- Refer and follow-up on any program integrity issues identified during oversight activities to DHS-MCOD and DDS Federal Programs Operations Section for investigation, and to DDS Audits and DHS Medi-Cal Policy Division for information.
- Review working papers prepared by DDS audit staff of regional centers on a sample basis and attend entrance and exit conferences of selected regional center audits.
- Participate in full-scope monitoring reviews are required.
- Issue an annual report to DHS Director and to CMS that summarizes oversight functions performed.

II. DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS) - ADMINISTRATION AND OVERSIGHT

Administration and Fiscal Intermediary

Through an interagency agreement with the Department of Health Services (DHS), DDS is responsible for serving as the fiscal intermediary for DHS in the payment for home and community based waiver services provided to persons with developmental disabilities through the California regional center system. DDS performs the following general administrative functions:

- Operating billing and payment systems.
- Maintaining consumer data and management information systems.
- Ensuring provider agreement and standards of participation.
- Preparing required reports.
- Promulgating necessary policies and procedures for use by regional centers.

Monitoring and Oversight of Regional Centers

DDS contracts with 21 private, not-for-profit, corporations to operate regional centers which are responsible under State law for coordinating, providing, arranging, or purchasing all services needed for eligible individuals with developmental disabilities in California. All HCBS waiver services are provided through this system. It is DDS' responsibility to ensure, with the oversight of DHS, that the waiver is implemented by regional centers in accordance with Medicaid statute and regulation. DDS carries out this responsibility through the existing compliance review process, as described below.

Audits and Financial Accountability:

DDS performs fiscal audits of each regional center no less than every two years, and completes follow-up reviews of each regional center in alternate years. DDS will continue to require regional centers to contract with independent auditors to conduct an annual audit. The DDS audit is designed to "wrap around" the independent CPA audit to ensure comprehensive financial accountability.

DDS coordinates its activities with DHS Audits and Investigations, who review DDS' audit reports of the regional centers.

Program Policy Compliance

- The DDS review team includes DHS staff with specific duties assigned to prevent duplication of effort by the two departments.
- The review cycle is conducted every two years.
 - **The two-year review cycle consists of a statistically valid, stratified, statewide sample of 1,050 Waiver participants selected at random from three major residence types: 1) Own Home-Parent; 2) Community Care Facility; and, 3) Independent Living or Supported Living. The size of the sample for each regional center varies depending on each regional center's percentage of the statewide total of Waiver participants within each residence type.**
- The face-to-face visits include interviews with the consumer and his/her family or significant others, **involved direct support professionals** and on-site observation of programs.
- Ten consumers who had reportable special incidents during the review period are selected for a review of their records to assess the extent to which identified problems or issues were addressed in a timely and appropriate manner to continuously assure the health and safety of participants.
- DDS may, at its own discretion, or in response to a complaint, do unannounced visits to a regional center or a provider.

Program Policy Follow-up Compliance Reviews.

During the off-year cycle of the two-year reviews, DDS and DHS conduct a comprehensive follow-up monitoring and compliance review at each of the 21 regional centers. This follow-up review focuses on the areas requiring implementation of a corrective action plan as identified by the previous compliance review, and progress in areas where changes were recommended. DDS provides on-going training and technical assistance as needed during the review process. The training and technical assistance covers, at a minimum, all aspects of the waiver program, and is designed to address the needs of administrators, case managers, and clinicians. Because the training and technical assistance is tailored to each individual regional center's needs and is delivered on-site, it affords maximum opportunity to follow-up on issues identified in the compliance reviews.

Quality Assurance

The Department oversees the overall design and operation of a quality assurance program which allows it to continually plan, assess, assure, and improve the quality and effectiveness of services and the level of satisfaction of consumers. The system is outcome-based, focusing primarily on its customers, but also on its services and operations. The following are the key components of the State's quality assurance system:

- Through the planning team, development and periodic review of an individualized program plan for each consumer that addresses his or her health, living, and support needs.
- For licensed residential health and community care facilities, annual certification and licensing evaluations by DHS and the Department of Social Services, respectively.
- Through the Life Quality Assessment (LQA) process during a face-to-face meeting, evaluation in the areas of health and well-being, choice, relationships, lifestyle, rights and satisfaction for every consumer receiving community residential services and supports. The area boards have responsibility for completion of the LQA.
- Quarterly monitoring visits by the regional center for each person living in licensed residential health and community care facilities or receiving services from supported living or family home agencies.
- Enhanced case management for individuals moving from developmental centers to community living arrangements.
- Department and regional center review and follow-up on special incidents.
- Annual review by the regional centers of each community residential care facility to assure services are consistent with the program design and

- applicable laws, and development and implementation of corrective action plans as needed.
- Regional Center Quality Assurance Team evaluations of licensed community care facilities at least every three years.
- Review and investigation of health and safety complaints by protective services agencies, the State long-term care ombudsman, area boards, Protection and Advocacy, the Department, regional centers, licensing agencies, and/or law enforcement agencies.
- Training and technical assistance provided by the Department, regional centers, and the Department of Social Services' Technical Support Program to enhance service quality.

In addition to the above activities, the Department plans to:

- Continue implementation of a statewide, interagency Wellness Initiative to improve the health and well being of all consumers through increased access to medical, dental, and mental health services.
- ~~**Annually review a random sample of individual program plans at each regional center to assure that the provision of services to individuals is effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources.**~~
- Through face-to-face interviews, track individuals that move into the community from State developmental centers to ensure that all necessary services and supports are provided.
- Contract with Protection and Advocacy, Inc. for clients' rights advocacy services to individuals with developmental disabilities residing in the community.

HCBS WAIVER INTERAGENCY OVERSIGHT PLAN

	REGIONAL CENTERS	DDS	DHS	DSS/CCL
<p>FISCAL INTEGRITY</p> <ul style="list-style-type: none"> - overall fiscal integrity - paper trail for federal billing - prior authorization - third party liability - service code utilization - federal single audit act 	<ol style="list-style-type: none"> 1. Annual CPA audits. 2. Provider audits. 	<ol style="list-style-type: none"> 1. "Wrap-around" audits of RCs on a two-year schedule. 2. Follow-up for compliance in alternate years 3. Special audits of providers. 4. Provider audit appeals 	<ol style="list-style-type: none"> 1. Review and approve DDS audit protocols. 2. Review and approve DDS audits of RCs & service providers 3. DHS-MCOD will refer fiscal integrity issues, identified during DHS monitoring reviews, to DDS Audits and DHS A&I for investigation. 	N/A
<p>PROGRAM POLICY COMPLIANCE</p> <ul style="list-style-type: none"> - interagency agreement - level-of-care determinations - freedom of choice - provider agreements - plans of care (IPPs) and annual reviews. - complete records 		<ol style="list-style-type: none"> 1. <u>Expanded</u> Federal compliance reviews on a two-year schedule: <ul style="list-style-type: none"> - 50 record reviews - 25 face to face reviews 2. Follow-up reviews, training and technical assistance as needed during off years. 3. DDS may do unannounced visits to a regional center or a provider. 	<ol style="list-style-type: none"> 1. Develop and monitor Interagency Agreement. 2. DHS Oversight Protocol <ul style="list-style-type: none"> - Follow-up Reviews. - Full-scope Monitoring Reviews - Remain apprised of DDS application of sanctions. 3. DHS A&I will refer/follow-up program integrity issues, identified during DHS monitoring reviews to DHS-MCOD and DDS for investigation. 	N/A
<p>CONSUMER HEALTH AND WELFARE</p> <p><i>Ensuring that all waiver consumers are healthy, safe and receiving appropriate, quality services.</i></p>	<ol style="list-style-type: none"> 1. Case management at 1:62 2. Quarterly face to face for monitoring. 3. Clinical teams consultation and monitoring 	<ol style="list-style-type: none"> 1. Face to face reviews during scheduled RC visits. 2. Interviews. 3. Wellness projects. 4. Training. 5. Unannounced visits to RC or provider (see #3 above) 6. Data collection/trend analysis 	<ol style="list-style-type: none"> 1. Oversight protocol. 2. DHS Independent Focus Review. 3. Review data collection/trend analysis provided by DDS. 	<ol style="list-style-type: none"> 1. Unannounced annual visits. 2. Complaint investigations. 3. Incident Report review. 4. Administrator certification 5. Technical support.
<p>COMMUNITY CARE FACILITY COMPLIANCE AND QUALITY ASSURANCE</p>	<p>Quarterly monitoring</p>	<p>Training program for CCF's</p>	<p>Refer issues identified during DHS monitoring reviews, related to non-compliance with CDSS, CCL requirements for investigation</p>	<p>Annual reviews</p>

III. DEPARTMENT OF SOCIAL SERVICES (CDSS) - MONITORING AND OVERSIGHT PROCEDURES FOR COMMUNITY CARE FACILITIES (CCF)

Developmentally disabled consumers that are part of the home and community-based waiver are frequently placed in facilities licensed by CDSS. The Community Care Facilities Act mandates that community care facilities be inspected to verify compliance with licensing laws and regulations. The following is a description of the oversight procedures and the types of visits conducted by CDSS Community Care Licensing Division (CCLD):

A. Monitoring Activities

Pre Licensing

A scheduled announced Pre Licensing visit is conducted to ensure that a facility is in compliance with physical *plant* requirements before a license is approved.

Annual Evaluations

All CCF's are inspected annually and core requirements are always reviewed. Core requirements include, but are not limited to, staff criminal record clearance, health-related and food services, care and supervision and physical plan conditions. The annual visits are unannounced and can be a comprehensive, in-depth review of facilities operation. The scope of the annual review is based on the facilities compliance history. A facility that has been maintained in substantial compliance may have an annual review that does not include certain aspects that have been looked at during the previous annual visit and found to be in compliance. For instance, if client files were reviewed during the previous annual visit and found to be in compliance, client files might not be reviewed at the next annual visit.

A complete report including what was reviewed, deficiencies observed and a plan for correcting those deficiencies is prepared at the time of the visit. The licensing analyst reviews the report with the licensee, administrator, or designee, and the licensee, administrator, or designee, in consultation with the licensing analyst creates the Plan of Correction (POC) for the deficiencies. The time frame to complete the corrections must correlate with the severity of the violation. Violations that threaten the health and safety of clients could have a POC due date of less than 24 hours. Less serious violations may be corrected in a maximum of 30 days.

Plan of Correction Visit

A plan of correction visit is made to verify the correction of previously cited deficiencies (documented evidence of correction of some deficiencies may be submitted by mail). The visit is unannounced and must be made within 10 days of the agreed upon correction date. If deficiencies are not corrected, a civil penalty may be assessed.

Management Visits

Management visits are follow-up visits to verify the facility's continued compliance. The visits are unannounced and are made as often as necessary depending on the nature of the violation or concern.

Complaints

Complaints or allegations of a violation of licensing regulations are made by telephone, mail, or in person. All complaint allegations are investigated and a site visit must be conducted within 10 days of receipt of the complaint. All analysts receive training in complaint investigations and various methodologies are used to determine whether a violation has occurred. Supervisors review all completed investigations. Complaints involving **suspected-serious** physical abuse, sexual assault, or **suspicious** deaths are referred to CCLD's Regional Investigative Services. Each of CCLD's four regions has a staff of approximately 10 investigators who have peace officer status. In cases where local law enforcement is conducting a criminal investigation of the abuse suspects, both entities coordinate their investigations and share reports.

At the initial complaint visit the licensee is given an estimated date of completion of the complaint investigation. Once the complaint investigation is concluded, the licensee is given a complete report with the complaint findings. All complaints are confidential during the investigation. Reports involving substantiated or inconclusive findings are available to the public and maintained at the respective CCLD District Office once the investigation has concluded. Unfounded complaint reports are placed in a confidential section of the facility file and are not available for public viewing.

Incident Report Follow-up Investigation

Incident reports are not recorded as complaints. However, an investigation may be required depending on the nature of the incident, especially if abuse or neglect is suspected. For example, it may be necessary to obtain copies of police reports, medical records, death certificates, etc., to ensure the client received the necessary medical treatment and the licensee was not in violation of any regulation. The investigation may require interviews with victims, witnesses to the incident, and other clients in the care home. If the documents and information collected during the investigation are complete and address all issues and concerns regarding the incident, it may not be necessary to conduct additional interviews or make a facility visit. For instance, if a serious injury or death has occurred which has been investigated by law enforcement, a copy of the police, sheriff, or coroner's report may be sufficient.

If a questionable death has occurred, an investigation by CCLD must always be conducted. In these situations, analysts evaluate the incident report carefully and then formulate a plan to collect, examine and analyze all the facts and evidence available.

Technical Support

The CCLS Technical Support Program (TSP) assists residential care providers to achieve and maintain compliance with licensing regulations. The use of the TSP is on a voluntary basis and facilities that the Department has identified as having compliance issues are given highest priority for this service. Technical Support staff provide individualized facility consultations and group-training sessions for care providers with common training needs. The focus of technical assistance and training is to provide preventative assistance as opposed to inspection and enforcement, which has been the traditional method by which CCLD has operated its programs.

Compliance Activities

A range of corrective actions are taken when a provider fails to protect the health and safety of clients in care or is unwilling or unable to maintain compliance with licensing regulations. The CCLS's system of sanctions for non-compliant facilities include:

Civil Penalties-

If a plan of correction visit indicated that a deficiency was not corrected, or if a documentation verifying correction has not been submitted by the date agreed upon, a notice of penalty is issued. A penalty of \$50 per day is assessed until the correction is made. In addition, civil penalties of larger dollar amounts can be assessed under certain conditions for repetitive or specific serious violations.

Facility Compliance Plan-

The Facility Compliance Plan is used to formalize a plan of specific actions to resolve facility problems prior to the need for a Non-compliance Conference. An Informal Meeting is held to thoroughly discuss the plan with the licensee and reach an agreement for correcting the problems. The licensee is advised at the end of the Informal Meeting that failure to correct deficiencies by the agreed upon date could result in a Non-compliance Conference.

Non-compliance Conferences-

The Non-compliance Conference is the last step prior to initiating administrative action following unsuccessful attempts by the licensing analyst and the supervisor to gain compliance. These efforts may include the repeated citation of licensing violations, the issuance of civil penalties and informal meeting or telephone conversations regarding compliance. The Non-compliance Conference occurs when the problems have not been corrected and legal action is otherwise the next step. The purpose of the conference is to review problem areas and impress upon the licensee the seriousness of the situation. The licensee is informed that unless the deficiencies are corrected and continued compliance is maintained, the case will be referred for possible administrative action. Following review and approval from the respective Regional Managers,

the CDSS' legal division handles the cases referred for administrative action.

Administrative Action-

After the district office has utilized all available and appropriate enforcement actions, if the licensee is still failing to comply, administrative action is the last step in the process. Administrative action simply refers to the process necessary to present a case in an administrative hearing. Such hearings may lead to the following:

- Denial of Application
- License Revocation
- Temporary Suspension Order
- Injunctions
- Exclusion Actions

B. Procedures for Communication and Collaboration

The CDSS and DDS have developed a Memorandum of Understanding that includes the following:

- Coordination of complaint investigations
- Coordination of incident report investigation
- Coordination of optimal spacing of CDSS annual visits and Regional Center visits
- Sharing of all field reports, including complaints and incident report follow-up investigations
- Involvement of RC when CDSS is taking Administrative Action against a facility

IV. HCBS WAIVER INTERAGENCY AGREEMENTS

1. DHS and DDS - Interagency Agreement (IA) for administration of the new waiver

Purpose: To define, specify, and clarify the roles and responsibilities of DDS and DHS in the administration of the waiver; to specify the functions to be performed by DDS to ensure the "proper and efficient" administration of the waiver; to specify the cost allocation plan; to transfer federal funds to DDS.

Status: **The current IA effective July 1, 2003 is still in effect.**

2. DHS and DDS - IA for fiscal intermediary (FI) responsibilities

Purpose: To specify the billing and payment responsibilities of DDS as they pertain to "fiscal intermediary" in accordance with Medicaid rules on "direct payment".

Status: **The current IA effective July 1, 2001 is still in effect.**

3. DDS and the Department of Social Services, Community Care Licensing Division - MOU for joint monitoring and quality assurance responsibilities

Purpose: Implementation of a coordinated system of services to regional center consumers residing in licensed community care facilities.

Status: Current MOU, effective June 30, 1998, is still in effect.

4. DDS and the Department of Mental Health (Regional Centers / County Mental Health Agencies -- MOU

Purpose: Implementation of a coordinated system of mental health services to individuals who are eligible for developmental services and require services for mental illness.

Status: Current MOU, effective July 1, 1998, is still in effect.

ATTACHMENT #2 TO APPENDIX A

REGIONAL CENTER ACCOUNTABILITY/MONITORING

REGIONAL CENTER ACCOUNTABILITY/MONITORING

The Department of Developmental Services (DDS) performs a number of monitoring activities through the Regional Center Operations Section (RCOS). Below is a brief description of the activities performed by the RCOS. Monitoring activities are also conducted by the Department's Audits Section and the Federal Programs Operations Section.

Review and Monitor Regional Center Performance Contracts

- The Department annually prepares and transmits the guidelines for developing performance contracts.
- **Performance contracts include statewide public policy and compliance measure outcomes based on the Lanterman Act and the regional centers' contract with DDS.**
- Each regional center's performance contract is developed through a local public process and includes **activities for achieving public policy outcomes and any local measures the regional center and its local community agree to pursue. five-year goals and annual objectives within the nine performance standard areas.**
- By November 1 of each year, regional centers submit to DDS annual performance contracts **for the following calendar year. objectives and/or revisions to performance contracts approved with multi-year objectives.**
- ~~**Objectives are to be measurable, include a baseline and focus on outcomes for consumers.**~~
- The Department reviews each performance contract for compliance with statute, regulations, and DDS guidelines.
- Centers must submit revisions in writing for DDS review and approval.
- A performance contract year-end report **for any local measures** is due to DDS by January 31.
- **DDS generates public policy and compliance measure outcomes data and provides to each regional center in a year-end report.**
- ~~**DDS seeks to attend at least one performance contract public hearing at each regional center.**~~

Review and Follow-up on Special Incident Reports (SIRs)

Currently, DDS maintains a database of special incident reports submitted to the Department by the regional centers pursuant to regulations.

DDS reviews each SIR to ensure the appropriate licensing and protective services/law enforcement agencies are notified.

Trend analysis is conducted monthly. Regional centers are notified when a consumer and/or facility is involved in two or more SIRs within a one-year period of time.

Risk Management System

California has implemented an innovative and comprehensive risk management system. The system enables the State to identify the factors that comprise consumers' health, safety, and/or well-being and implement preventative strategies and interventions to mitigate such risks. This system is statewide and apply to all regional center consumers, regardless of whether or not they are on the HCBS Waiver.

Monitor Regional Centers' Contract Compliance

- Monitor regional center's compliance with special contract language provisions.
- Review and respond to complaints and correspondence received from consumers/families, vendors, Legislators, and other entities regarding regional centers.
- Conduct special program reviews of regional centers, as appropriate to address specific concerns.

Contract Non-compliance/Non-Renewal

- Technical assistance
- Special contract language
- Probationary status (levels)
- Contract non-renewal - Contract termination (see matrix)

REGIONAL CENTER CONTRACT TERMINATION ACTIVITIES AND DUE DATES

ACTIVITY	DUE DATE
1. Department of Developmental Services (DDS) gives Regional Center (RC) board president written "90-day Notice of Intent to Terminate Contract". Copy of letter sent to RC's Executive Director, Area Board (AB) and State Council on Developmental Disabilities (SCODD) (W&I Code 4635{d})	DAY 1
2. DDS informs catchment area legislators and others of intent to terminate RC contract (No reference in law)	DAY 1
3. RC may submit written protest of 90-day notice to DDS within 14 days of receipt of notice. (W&I Code 4635 {d}) If No Protest, Skip To #10	DAY 14
4. DDS arranges (in writing) to meet with RC and AB in response to 14-day protest. Discussion includes DDS decision and rationale and/or possible alternatives to termination (W&I Code 4635 {d})	ASAP after receipt of 14-day notice.
5. DDS initiates procedure in W&I Code 4632 for resolving contract dispute by asking SCODD to review and advise on issues in dispute. (W&I Code 4635 {d})	No time specified in law but would submit during same time frame as #4.
6. SCODD reviews issues and provides written advice to DDS and RC board of directors. Advice not binding upon DDS or RC. (W&I Code 4632)	Within 30 days of DDS' request to review and advise.
7. DDS meets with RC and area board to discuss issues, DDS rationale for notice and possible alternatives. May include SCODD. (W&I Code 4632 and 4635 {d})	Must take place within 30 days of regional center 14-day protest.
8. DDS sends written notification of final decision to RC board president. If termination stands, letter will: <ul style="list-style-type: none"> a. request meeting with RC to discuss transition; b. invoke bank card provisions per contract. Copy of the letter is sent to RC Executive Director, AB, SCODD, and appropriate legislators. (No reference in law)	By DAY 59 or within 10 days following joint meeting and review of SCODD's recommendation (Law does not cite a date for this activity. Historically DDS has sent notification 30 days prior to the 90-day intent period.)
9. DDS sends written notification to the following advising that DDS has decided to terminate RC contract: AB, SCODD, consumers; services providers, RC employees, and union, if applicable (W&I Code 4635 {e}[1])	Mail by DAY 59
10. DDS management team begins transition and planning activities. (No reference in law)	DAY 62
11. RFP issued for a new governing board. (W&I Code 4635 {e}[2])	DAY 62
12. DDS has RC employees execute personal services contract.	DAY 80
13. DDS requests assistance from AB and other appropriate community agencies in identifying or organizing a new governing board. (W&I Code 4635 {e}[3])	No date specified in law, but within time frames required by RFP.
14. 90-day period ends and DDS takes over management of RC until new contractor named. (Not to exceed 120 days unless otherwise requested). (W&I Code 4636)	DAY 90

ACTIVITY	DUE DATE
15. Proposals received.	DAY 120
16. AB submits recommendations regarding proposals to DSS. (W&I Code 4635 {e}[2])	DAY 127
17. DDS reviews proposals and selects new contractor.	DAY 132
18. Post Notice	DAY 133
19. Mail "Notice of Award" and contract to contractor.	DAY 140
20. Contractor term begins.	DAY 147
21. DDS transition team exits	DAY 177

Prepared 3/11/96 by DDS Regional Center Branch

ATTACHMENT #3 TO APPENDIX A

- [Title 17, California Code of Regulations, Section 50500, Clients' Rights](#)
- [Title 17, California Code of Regulations, Section 50515, Use of Exclusion or Restraint, "Time Out"](#)
- [Title 17, California Code of Regulations, Section 50800 – Peer Review of Behavior Interventions That Cause Pain or Trauma, and Electroconvulsive Therapy](#)
- [Title 17, California Code of Regulations, Section 54327, Requirements for Special Incident Reporting by Vendors and Long-Term Health Care Facilities](#)
- [Title 17, California Code of Regulations, Section 54327.1, Requirements for Special Incident Reporting by Regional Centers](#)
- [Title 17, California Code of Regulations, Section 54327.2, Regional Center Risk Management, Assessment and Planning Committee and Risk Management and Mitigation Plans](#)

APPENDIX B - SERVICES AND STANDARDS**APPENDIX B-1: DEFINITION OF SERVICES**

The State requests that the following home and community based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each services are set forth in Appendix B-2.

a. Case Management:

Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. Yes2. No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices D & E of this request.

1. Yes2. No

Other Service Definition (Specify): Case management under this waiver is provided through the Targeted Case Management benefit contained in California's Medicaid State Plan.

b. Homemaker:

Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

Other Service Definition (Specify):

c. Home Health Aide services:

Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

Other Service Definition (Specify):

d. Personal care services:

Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

Payment will not be made for personal care services furnished by a member of the individual's family.

Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

Family members who provide personal care services must meet the same standards as providers who are unrelated to the individuals.

Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

A registered nurse, licensed to practice nursing in the State.

A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

Case managers

Other (Specify):

3. Frequency or intensity of supervision (Check one):

As indicated in the plan of care

Other (Specify):

4. Relationship to State plan services (Check one):

Personal care services are not provided under the approved State plan.

Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

Other Service Definition (Specify):

- e. Respite care:

Services provided to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Other Service Definition (Specify):

Intermittent or regularly scheduled temporary non-medical care and supervision provided in the consumer's own home or in an approved out-of-home location to do all of the following:

1. Assist family members in maintaining the consumer at home;

2. Provide appropriate care and supervision to protect the consumer's safety in the absence of family members;
3. Relieve family members from the constantly demanding responsibility of caring for a consumer; and
4. Attend to the consumer's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines which would ordinarily be performed by the family member.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s). (Check all that apply):

- Individual's home or place of residence
- Family member's home
- Foster home
- Medicaid certified Hospital
- Medicaid certified NF
- Medicaid certified ICF/MR
- Group home
- Licensed respite care facility must be licensed by CCLD as either an Adult Residential Facility, Residential Care Facility for the Elderly, Small Family Homes, Group Homes, or Foster Family Homes.
- Other community care residential facility approved by the State that is not a private residence (Specify type):
 - Adult Family Homes
 - Certified Family Homes
 - Adult Day Care Facility
 - Community Recreational Setting, such as YMCA, Sports Club, Community Parks & Recreation Program or other community based recreational program
 - Camping Services
 - Child Day Care Facility
 - Licensed Preschool

Voucher Respite Care: A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own respite services. Family members are defined in State regulations (Title 17, Article 2, Section 54302) as an individual who:

- has a developmentally disabled person residing with him/her;
- is responsible for the 24-hour care and supervision of a developmentally disabled person; and

- is not a licensed or certified residential care facility or foster family home receiving funds from any public agency or regional center for the care and supervision provided.

Voucher Respite services may be procured from an individual, respite agency, respite facility, licensed residential facility, licensed adult day care, child day care facility, or licensed preschool. When vouchers are issued they shall be used in lieu of, and shall not exceed the cost of, services the regional center would otherwise provide and be issued only for services which are unavailable from generic agencies. Individual voucher respite providers must meet the certification standards for hourly and overnight respite service providers in Appendix B-2.

The Department, in support of maximum personal control over the supports and services purchased through the Waiver, offers a voucher payment method for respite. This is an option that may be selected instead of respite provided by staff hired by an authorized agency through the Regional Center. Voucher services will empower families, or the consumer, by giving them direct control over how and when the services are provided and will enable closer scrutiny of the quality of those services. Voucher respite care may be provided only if approved in the recipient's plan of care (IPP). Services under this option will be administered as follows:

1. The vendored family member or consumer will select and train an individual to render respite services. Services may also be obtained from a respite agency, residential or day care facility, or preschool [out-of-home respite], or respite facility.
2. The vendored family member or consumer signs an agreement with the Regional Center acknowledging responsibility for compliance with Waiver caregiver qualifications (See Appendix B-2) and Internal Revenue Service laws.
3. The Regional Center issues the vouchers to the family or consumer based on the number of authorized hours of service pursuant to the IPP (plan of care).

f. ____ Adult day health:

____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health

services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. Yes

2. No

Other Service Definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. Habilitation:

Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

Residential habilitation for children services: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies

listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

- ___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Check one:

- ___ Individuals will not be compensated for prevocational services.
- ___ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in these services are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

- ___ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

- ___ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities,

X Other service definition (Specify):

- X Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which take place in a residential and non-residential setting. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation service may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Whenever individuals are found ineligible under existing HCBS waiver supported employment or prevocational services, day habilitation service may utilize paid work strategies as a treatment modality. Day habilitation paid work modalities shall be stated in the individual's plan of care and coordinated with other services listed in the plan of care.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; or
2. Payments for vocational training that is not directly related to an individual's supported employment program.

X Supported employment:

Supported employment services are defined in California Welfare and Institutions Code §4851 (n), (r), and (s). These services are received by adult individuals with developmental disabilities who are employed in integrated settings in the community. For purposes of these services, “adult” is defined as an individual 18 years of age or older. These individuals are unable to maintain this employment without an appropriate level of ongoing employment support services.

Generally, these individuals have previously received vocational rehabilitation services under section 110 of the Rehabilitation Act of 1973, including intense job supervision. The supported employment services provided under the HCBS waiver will be provided to these individuals who require ongoing support services to maintain their employment after such services are no longer funded by the vocational rehabilitation program.

The supported employment services provided under the HCBS waiver include:

Group Supported Employment (defined in California Welfare and Institutions Code §4851 (r).

- Training and supervision of an individual while engaged in work in an integrated setting in the community.

Consumers in group-supported employment receive supervision 100% of the time by the program and usually are paid according to productive capacity. A particular consumer may be compensated at a minimum wage or at a rate less than minimum wage.

Individual Supported Employment (defined in California Welfare and Institutions Code §4851 (s).

- Training and supervision in addition to the training and supervision the employer normally provides to employees.
- Support services to ensure job adjustment and retention, provided on an individual basis in the community, as defined in California Welfare and Institutions Code §4851 (q), such as:
 - Job development
 - Job analysis
 - Training in adaptive functional skills
 - Social skill training
 - Ongoing support services (e.g., independent travel, money management)

X Pre-vocational services:

These services are work activity program as defined in California Welfare and Institutions Code §4851 (e). These services are usually provided in a segregated setting and provide a sufficient amount and variety of work to prepare and maintain adult individuals, with developmental disabilities, at their highest level of vocational functioning. For purposes of these services, "adult" is defined as an individual who is 18 years of age or older. Consumers receive compensation based upon their productive capacity and upon prevailing wage. Accordingly, the rate of compensation for any individual consumer varies, and may exceed 50% of minimum wage, because of variations in the prevailing wage rate for particular tasks and the individual's productivity in performing the task.

Services are limited to:

- Work services consisting of remunerative employment which occur no less than 50% of the client's time in program, as defined in Title 17, California Code of Regulations, Section 58820(c)(1).
- Work adjustment services, as defined in Title 9, California Code of Regulations, Sections 58801(d)(37) and 58820 (c)(2)(A)-(I), consisting of:
 - Physical capacities development (e.g., general work stamina)
 - Psychomotor skills development (e.g., eye-hand coordination, tool usage)
 - Interpersonal and communicative skills development (e.g., relations with supervisor, co-workers)
 - Work habits development (e.g., attendance, punctuality)
 - Development of vocationally appropriate dress and grooming
 - Productive skills development (e.g., quality and quantity of work)
 - Work practices training (e.g., payroll deductions, safety practices)
 - Work-related skills development (e.g., counting, measuring, money management)
 - Orientation and preparation for referral to Vocational Rehabilitation

Such work adjustment services must occur in the work setting, be work related and not exceed 25% of the client's time in program.

- Supportive habilitation services as defined in Title 17, California Code of Regulations, §58820(c)(3)(A)-(E), include:
 - Personal safety practices training
 - Housekeeping maintenance skills development

- Health maintenance skills development, such as hygiene skills
- Self-advocacy training, consumer counseling, peer vocational counseling, career counseling and peer club participation
- Other regional center approved vocationally related activities

No more than 25% of the consumer's time in program can be spent in supportive habilitation services.

The above-described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)). While consumers are receiving these prevocational services, they may become eligible for vocational rehabilitation services funded by section 110 of the Rehabilitation Act of 1973 ("vocational rehabilitation program"); when and if the consumer begins receiving services under the vocational rehabilitation program, prevocational services will cease and the vocational rehabilitation services will not be considered or claimed as HCBS waiver services.

The State requests authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. X Environmental accessibility adaptations:

- X Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

It may be necessary to make environmental modifications to an individual's home before he/she transitions from an institution to the community. Such modifications may be made while the person is institutionalized. Environmental modifications, included in the individual's plan of care, may be furnished up to 180 days prior to the individual's discharge from an institution. However, such modifications will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver.

In the event an individual dies before the relocation can occur, but after the modifications have been made, the State will claim FFP at the administrative rate of 50% for services that would have been necessary for relocation to have taken place when the individual has:

- applied for waiver service; and
- been found eligible for the waiver by the State (but for the person's status as an inpatient in an institution); and
- died before the actual delivery of the waiver service.

____ Other service definition (Specify):

i. X Skilled nursing:

- X Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or

licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

___ Other service definition (Specify):

j. X Transportation:

X Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined in 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care and shall include transportation aides and such other assistance as is necessary to assure the safe transport of the recipient. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

___ Other service definition (Specify):

k. X Specialized Medical Equipment and Supplies:

___ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

X Other service definition (Specify):

Specialized medical equipment and supplies: to include devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. The repair, maintenance, installation, and training in the care and use, of these items is also included. Items reimbursed with wavier funds shall be in addition to any medical equipment and supplies furnished under the

State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. This service is necessary to prevent institutionalization. All items shall meet applicable standards of manufacture, design, and installation, and must meet Underwriter's Laboratory or Federal Communications Commission codes, as applicable. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealer where possible.

I. Chore services:

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, and minor repairs such as those which could be completed by a handyman. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Other service definition (Specify):

m. Personal Emergency Response Systems (PERS):

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individuals may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Other service definition (Specify):

PERS is a 24-hour emergency assistance service which enables the recipient to secure immediate assistance in the even of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the recipient and includes training, installation, repair, maintenance, and response needs. The following are allowable:

1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;

4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders;
7. Monitoring services;
8. Light fixture adaptations (blinking lights, etc.);
9. Telephone adaptive devices not available from the telephone company;
10. Other electronic devices/services designed for emergency assistance.

PERS services are limited to those individuals who have no regular caregiver or companion for periods of time, and who would otherwise require extensive routine supervision. By providing immediate access to assistance, PERS services prevent institutionalization of these individuals. PERS services will only be provided as a waiver service to individuals in a non-licensed environment.

All Items shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers where possible. The cost effectiveness of this service is demonstrated in Appendix G.

n. Adult companion services:

Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

Other service definition (Specify):

o. Private duty nursing:

Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

Other service definition (Specify):

p. Family training:

Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-

laws, or unpaid friends or companions who need training to support the individual. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home, and may be provided in a group or on an individual basis. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q. ___ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

___ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

___ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

___ Other supervisory arrangements (Specify):

___ Other service definition (Specify):

r. X Adult Residential Care (Check all that apply):

X Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home **or in a contiguous or attached residence**. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals that can be served cannot exceed **two three**. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

X Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility or family home certified by a Family Home Agency in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- Home health care
- Physical therapy
- Occupational therapy
- Speech therapy
- Medication administration
- Intermittent skilled nursing services
- Transportation specified in the plan of care
- Periodic nursing evaluations
- Other (Specify):

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services are extensions of professional services provided through the Medicaid State Plan or as an extended state plan benefit under this waiver. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

X Supported Living:

Supported living services includes any individually designed service, or assessment of the need for service, which assists an individual consumer to live in a home that they own or lease, which is not licensed, or the place of residence of a parent or conservator, with support available as often and for as long as it is needed. The purposes of supported living services include: assisting the consumer to make fundamental life decisions, while also supporting and facilitating the consumer in dealing with the consequences of those decisions, building critical and durable relationships with other individuals, choosing where and with whom to live, and controlling the character and appearance of the environment within their home. Supported living services are tailored to meet the individual's evolving needs and preferences for support, without having to move from the home of their choice. Examples of supported living services activities include: assistance with common daily living activities; meal preparation, including planning, shopping, cooking, and storage activities; routine household activities aimed at maintaining a clean, and safe home; locating and scheduling appropriate medical services, acquiring, using, and caring for canine and other animal companions specifically trained to provide

assistance; selecting and moving into a home; locating and choosing suitable house mates; acquiring household furnishings; settling disputes with landlords; becoming aware of and effectively using the transportation, police, fire, and emergency help available in the community to the general public; managing personal financial affairs; recruiting, screening, hiring, training, supervising, and dismissing personal attendants; dealing with and responding appropriately to governmental agencies and personnel, asserting civil and statutory rights through self-advocacy; building and maintaining interpersonal relationships, including a Circle of Support, participating in community life; and accessing emergency assistance, including the selection, installation, maintenance, repair, and training in the operations of, devices to facilitate immediate assistance when threats to health, safety, and well-being occur.

___ Other service description (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. ___ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of service(s) and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

- ___ Physician services
- ___ Home health care services
- ___ Physical therapy services
- ___ Occupational therapy services
- ___ Speech, hearing and language services
- ___ Prescribed drugs
- ___ Other State plan services (Specify):

t. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

X Vehicle Adaptations:

Vehicle adaptations are devices, controls, or services which enable recipients to increase their independence or physical safety, and which allow the recipient to live in their home. The repair, maintenance, installation, and training in the care and use, of these items are included. Vehicle adaptations must be performed by the manufacturer's authorized dealer. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealer where possible.

The following types of adaptations to the vehicle are allowable:

1. Door handle replacements;
2. Door widening;
3. Lifting devices;
4. Wheelchair securing devices;
5. Adapted seat devices;
6. Adapted steering, acceleration, signaling, and braking devices; and
7. Handrails and grab bars

Adaptations to vehicles shall be included if, on an individual basis, the cost effectiveness of vehicle adaptations, relative to alternative transportation services, is established. Adaptations to vehicles are limited to vehicles owned by the recipient, or the recipient's family and do not include the purchase of the vehicle itself.

The recipient's family includes the recipient's biological parents, adoptive parents, stepparents, siblings, children, spouse, domestic partner (in those jurisdictions in which domestic partners are legally recognized), or a person who is legal representative of the recipient.

Vehicle adaptations will only be provided when they are documented in the individual plan of care and when there is a written assessment by a licensed Physical Therapist or a registered Occupational Therapist.

It may be necessary to make vehicle adaptations before the individual transitions from an institution to the community. Such adaptations may be made while the person is institutionalized. Vehicle adaptations included in the individual's plan of care may be furnished up to 180 days prior to the individual's discharge from an institution. However, such adaptations will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver. Requests to adapt more than one vehicle for a waiver participant must be reviewed and approved by DDS, with DHS concurrence.

In the event an individual dies before the relocation can occur, but after the adaptations have been made, the State will claim FFP at the administrative rate of 50% for services that would have been necessary for relocation to have taken place when the individual has:

- applied for waiver service; and
- been found eligible for the waiver by the State (but for the person's status as an inpatient in an institution); and
- died before the actual delivery of the waiver service.

X Communication Aides:

Communication aides are those human services necessary to facilitate and assist persons with hearing, speech, or vision impairment to be able to effectively communicate with service providers, family, friends, co-workers, and the general public. The following are allowable communication aides, as specified in the recipient's plan of care:

1. Facilitators;
2. Interpreters and interpreter services;
3. Translators and translator services; and
4. Readers and reading services

Communication aide services includes evaluation for communication aides and training in the use of communication aides, as specified in the consumer's Individual Program Plan.

X Crisis intervention:

Crisis intervention services may be provided in the individual's current living arrangement or other appropriate setting (e.g., day program, school, community respite setting) and include consultation with parents, individuals, or providers of services to develop and implement individualized crisis treatment as well as supplemental direct services to the individual.

X Mobile Crisis Intervention

Mobile crisis intervention means immediate therapeutic intervention on a 24-hour emergency basis to an individual exhibiting acute personal, social, and/or behavioral problems. Mobile crisis intervention provides immediate and time limited professional assistance to individuals who are experiencing personal, social or behavioral problems which, if not ameliorated, will escalate and require that individual be moved to a more restrictive setting.

X Crisis Intervention Facility Services:

Crisis intervention facility services means temporary 24-hour residential treatment setting for persons who pose an immediate health and safety danger to self or others.

Payment for crisis intervention facility services does not include room and board.

X Nutritional Consultation:

Nutritional consultation includes the provision of consultation and assistance in planning to meet the nutritional and special dietary needs of waiver participants. These services are consultative in nature and do not include specific planning and shopping for, or preparation of meals for waiver participants.

X Behavior Intervention Services:

Behavior intervention services include use of behavior intervention programs, development of programs to improve the recipient's development, behavior tracking and analysis, and the fading of any intrusive intervention measures. The intervention programs will be restricted to generally accepted positive approaches.

X Specialized Therapeutic Services

Specialized Therapeutic Services are services that provide physical, behavioral/social-emotional health, and or dental health care that have been adapted to accommodate the unique complexities presented by HCBS enrolled individuals ~~aged 21 years or older~~. These complexities include requiring:

1. additional time with the health care professional to allow for effective communication with patients to ensure the most effective treatment;
2. additional time with the health care professional to establish the patient's comfort and receptivity to treatment to avoid behavioral reactions that will further complicate treatment;
3. additional time for diagnostic efforts due to the masking effect of some developmental disabilities on health care needs;
4. specialized expertise and experience of the health care professional in diagnosing health care needs that may be masked or complicated by a developmental disability;
5. treatment to be provided in settings that are more conducive to the patient's ability to effectively receive treatment, either in specialized

offices or facilities that offer better structured interaction with the patient or which may provide additional comfort and support which is needed to reduce patient anxiety that is related to his or her developmental disabilities.

All of these additional elements to Specialized Therapeutic Services are designed and proven effective in ensuring the health and safety of the patients who are enrolled in the HCBS waiver. They are also designed or adapted with specialized expertise, experience or supports to ensure that the impact of a person's developmental disability does not impede the practitioner's ability to effectively provide treatment. The design features and/or expertise levels required by these consumers have been developed through years of experience and are not available through existing State Plan services. These features are critical to maintain, preserve, or improve the health status and developmental progress of each individual, ~~aged 21 years or older~~, who is referred to these Specialized Therapeutic Services.

Specialized Therapeutic Services include:

1. Oral Health Services: Diagnostic, Prophylactic, Restorative, Oral Surgery
2. Services for Maladaptive Behaviors/Social-Emotional Behavior Impairments (MB/SEDI) Due to/Associated with a Developmental Disability: Individual and group interventions and counseling
3. Physical Health Services: Physical Therapy, Occupational Therapy, Speech Therapy, Respiratory Therapy, Diagnostic and Treatment, Physician Services, Nursing Services, Diabetes Self-Management

The need for a Specialized Therapeutic Service must be identified in the Individual Program Plan, also known as a Plan of Care, and is to be provided only when the individual's regional center planning team has:

1. Determined the reason why other generic or State Plan services can not/do not meet the unique oral health, behavioral/social-emotional health, physical health needs of the consumer as a result of his/her developmental disability and the impact of the developmental disability on the delivery of therapeutic services;
2. Determined that a provider with specialized expertise/knowledge in serving individuals with developmental disabilities is needed, i.e., a provider of State Plan services does not have the appropriate qualifications to provide the service;
3. Determined that the individual's needs cannot be met by a State Plan provider delivering routine State Plan services;
4. Determined that the Specialized Therapeutic Service is a necessary component of the overall Plan of Care that is needed to avoid institutionalization; and
5. Consulted with a Regional Center clinician.

The need to continue the Specialized Therapeutic Service will be evaluated during the mandatory annual review of the individual's IPP in order to determine if utilization is appropriate and progress is being made as a result of the service being provided.

The following specify the differences between Specialized Therapeutic Services and services available under the approved State Plan:

1. Provider qualifications.
2. The scope (what is provided).
3. The services will be offered either at the consumer's home, the program site, or when appropriate, the provider's site.

Providers of Specialized Therapeutic Services must hold a current State license or certificate to practice in the respective clinical field for which they are vendored and have at least one year of experience working providing direct care in the field of licensure with persons with developmental disabilities, validation of which must be obtained by the regional center prior to vendorization and maintained in the regional center vendor file. This expanded qualification requirement differentiates providers of Specialized Therapeutic Services from State Plan providers. These providers include physicians/surgeons, nurse practitioners, registered nurses, licensed vocational nurses, psychologists, social workers, speech therapists, physical therapists, physical therapy assistants, dental hygienists, dentists, and marriage and family therapists. Certified occupational therapists, occupational therapy assistants, respiratory therapists, and chemical addiction counselors are also included. Authorized providers and State authorization requirements are further delineated in Appendix B-2, pages B-58 and B-59, and in Attachment #1 to Appendix B-2, pages B-87 and B-87.

Scope of Services: When provided as a home and community-based service, a Specialized Therapeutic Service may require one or more of the following if determined critical to the ongoing maintenance of the oral care, health care, or behavioral/social-emotional health care of the individuals in his/her residence or program environment. This expansion of the scope of the Specialized Therapeutic Service differentiates it from other State Plan services. These are provided as a component of an allowable specialized therapeutic service, are billed to the Waiver as part of the specialized therapeutic service being provided, and are designed to improve the consumer or caregiver's capacity to effectively access services, interpret care instructions, or provide care as directed by the clinical professional. Each of these will be provided only if it is directly associated with a specialized therapeutic service provided to an individual and are included in an approved plan of care.

1. Family support and counseling - Critical to a full understanding of the impact of involved developmental disabilities on the presenting health care need and effective treatment. The health care

- practitioner delivering the health, dental, or behavioral/social-emotional health specialized services may need to provide family support and/or counseling, as well as consumer training and consultation with other physicians or involved professionals, in order to ensure the proper understanding of the treatment and support in the person's home environment and that it is critical to effective treatment of people with developmental disabilities;
2. Provider travel necessary to deliver the service - If cost-effective and necessary, the regional center may include the cost of travel in order to allow the provider to provide the care at a location that is necessary due to the disabilities of the individual;
 3. Consultation with other involved professionals in meeting the physical, behavioral/social-emotional health and/or dental health needs of the consumer through specialized therapeutic services. This allows the clinical provider of specialized therapeutic services to properly involve other professional care givers who deliver services in accordance with the individual's plan of care;
 4. Consumer training - at times the individual will require additional training by a specialized therapeutic service provider to maintain or enhance the long-term impact of the oral, behavioral/social-emotional health, or health care treatment provided. An appropriately licensed or certified provider, as defined above, will provide this training.

X Transition/Set Up Expenses

Transition/Set Up Expenses are one-time set-up expenses to assist individuals who are moving from an institution to their own home. These expenses fund some of the initial set-up costs that are associated with obtaining and securing an adequate living environment and address the individual's health and safety needs when he or she enters a new living environment.

"Own home" is defined as any dwelling, including a house, apartment, condominium, trailer, or other lodging that is owned, leased, or rented by the individual.

This service includes necessary furnishings, household items and services that an individual needs for successful transition to community living and may include: security deposits that are required to obtain a lease on an apartment or home, moving expenses, health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy, set up fees or non-refundable deposits for utilities (telephone, electricity, heating by gas), essential furnishings to establish basic living arrangements which are bedroom furniture, dining room furniture, kitchenware, and a telephone.

These services exclude:

- Items designed for diversionary/recreational/entertainment purposes, such as hobby supplies, television, cable TV access, or VCRs and DVDs.
- Room and board, monthly rental or mortgage expense, regular utility charges, household appliances, and food.

Items purchased through this service are the property of the individual receiving the service and the individual takes the property with him/her in the event of a move to another residence.

Some of these expenses may be incurred before the individual transitions from an institution to the community. In such cases, the Transition/Set Up expenses incurred while the person was institutionalized are not considered complete until the date the individual leaves the institution and is enrolled in the waiver. Transition/Set Up expenses included in the individual's plan of care may be furnished up to 180 days prior to the individual's discharge from an institution. However, such expenses will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver.

In the event an individual dies before the relocation can occur, but after the expenses have been incurred, the State will claim FFP at the administrative rate of 50% for services which would have been necessary for relocation to have taken place when the consumer has:

- applied for waiver service; and
- been found eligible for the waiver by the State (but for the person's status as an inpatient in an institution); and
- died before the actual delivery of the waiver service.

u. Services for individuals with chronic mental illness consisting of (Check one):

Day treatment or other partial hospitalization services (Check one):

Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

- ___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:
 - a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
 - b. social skills training in appropriate use of community services;
 - c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
 - d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

___ Other service definition (Specify):

___ Clinical services (whether or not furnished in a facility) are services defined in 42 CFR 440.90. Check one:

___ This service is furnished only on the premises of a clinic.

— Clinical services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

Pages B-31 – B-32
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APPENDIX B-2 - PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
HOMEMAKER:				
Homemaker	Individual			Further requirements in Attachment #1 to Appendix B-2. Title 17, CCR, §54342(a)(33). Vendored by the regional center in accordance with Title 17, CCR §§54310 and 54326. See Attachment #2 to Appendix B-2
Homemaker	Service Agency	Business License		Further requirements in Attachment #1 to Appendix B-2. Title 17, CCR, §54342(a)(34). Vendored by the regional center in accordance with Title 17, CCR §§54310 and 54326. See Attachment #2 to Appendix B-2

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
HOME HEALTH AIDE:				
Home Health Aide Services	Home Health Agency; Home Health Aide	HHA: Title 22, CCR, §74600 et. seq. CHHA: Title 22, CCR, §§74659-74689	Health and Safety Code §§1725-1742 HHA: Medi-Cal certification using Medicare standards, Title 22, CCR, §51217. CHHA: Title 22, CCR, §74624	Further requirements in Attachment #1 to Appendix B-2. HHA: Title 17, CCR, §54342(a)(31). CHHA: Title 17, CCR §54342(a)(32) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
RESPIRE:				
Respite	Individual			Title 17, CCR, §54342(a)(40). Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Respite	Service Agency	Business License		Title 17, CCR, §54342(a)(39). Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326 and Title 17, CCR, §§56780-56802. See Attachment #2 to Appendix B-2

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Respite	Adult Day Care Facility	Health and Safety Code §§1500 - 1567.8 Title 22 CCR, §§82000 - 82088.2		Further requirements in Attachment #1 to Appendix B-2 Title 17, CCR, §54342(a)(4). Title 22, CCR, §§80064 and 82064. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Respite	Residential Facility Respite Facility; Residential Facility	Health and Safety Code §§1500-1567.8; ARF: Title 22, CCR, §§85000-85092; RCFE: Title 22, CCR, §§87100-87730; SFH: Title 22, CCR, §§83000-83088; GH: Title 22, CCR, §§84000-84808; FFH: Title 22, CCR, §§89200-88587.1 FFA: Title 22, CCR, §§88000-88087	Family Home Agency/Adult Family Homes; Title 17, CCR, §§56075-56088 Certified Family Homes: Title 22, CCR, §88030	Further requirements in Attachment #1 to Appendix B-2. Out of home respite: Title 17, CCR, §54342(a)(58). Respite Facility: Title 17, CCR §54342(a)(72) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Respite - Community Recreational Program Setting	YMCA, Sports Club, Community Parks & Recreation Program, Community-based recreation program	Business License, if required by law		Qualifications and training of staff per agency guidelines Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Respite - Camping Services	Camp	Business License		Further requirements in Attachment #1 to Appendix B-2. Title 17, CCR, §54342(a)(15). Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Respite	Individual or Family (Vouchered Respite Care)		First Aide and/or CPR if required in the consumer's IPP	Further requirements in Attachment #1 to Appendix B-2. Title 17, CCR, §54355(g)(4)
HABILITATION:				
Residential Habilitation for Children Services	Foster Family Agency/ Certified Family Homes	Health and Safety Code §§1500-1567.8; Title 22, CCR, §§88000-88087	Certified Family Homes; Title 22, CCR, §88030	Title 17, CCR, §§54342(a)(68) and (a)(70); Title 22, CCR §§88000-88087. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Residential Habilitation for Children Services	Foster Family Homes	Health and Safety Code §§1500-1567.8; Title 22, CCR, §§89200-89587.1		<p>Title 17, CCR, §§54342(a)(68) and (a)(70); Title 22, CCR §§89200-89587.1</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Residential Habilitation for Children Services	Small Family Homes	Health and Safety Code §§1500-1567.8; Title 22, CCR, §§83000-83088		<p>Further requirements in Attachment #1 to Appendix B-2</p> <p>Title 17, CCR, §§54342(a)(68) and (a)(70); Title 22, CCR §§83000-83087.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Residential Habilitation for Children Services	Group Homes	Health and Safety Code §§1500-1567.8; Title 22, CCR, §§84000-84369		<p>Title 17, CCR, §54342(a)(68) and (70); Title 22, CCR, § 84000-84369</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Residential Habilitation for Children Services - Out-of-State Residential Treatment Program	Residential facilities for children	Appropriate Facility License, as required by appropriate State law.		Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Residential Habilitation for Children Services – DSS Licensed – Specialized Residential Facility - Children	Residential facilities for children	Health and Safety Code §§1500-1567.8; Appropriate license by DDS-CCLD as to type of facility		Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Residential Habilitation for Children Services - Supplemental Program Support	Residential facilities for children - Staff	Health and Safety Code §§1500-1567.8; Appropriate license by DDS-CCLD as to type of facility		Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Day Habilitation	Mobility Training Services Agency	Business License		Further requirements in Attachment #1 to Appendix B-2 Title 17, CCR, §54342(a)(47). Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Day Habilitation	Mobility Training Services Specialist			<p>Further requirements in Attachment #1 to Appendix B-2 Title 17, CCR, §54342(a)(48).</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Day Habilitation	Adaptive Skills Trainer			<p>Further requirements in Attachment #1 to Appendix B-2 Title 17, CCR, §54342(a)(3).</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Day Habilitation - Community Integration Services	<p>Personal Assistance: Individual;</p> <p>Socialization Training Program: Agency;</p> <p>Community Integration Training Program: Agency; Community Activities Support Services: Individuals.</p>	Business License, if required by law		<p>Qualifications and training of staff per agency guidelines. Further requirements in Attachment #1 to Appendix B-2</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Day Habilitation - Day Program	Activity Center			<p>Further requirements in Attachment #1 to Appendix B-2</p> <p>Title 17, CCR, §54342(a)(1); Title 17, CCR, §§56710-56756.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Day Habilitation - Day Program	Adult Development Centers			<p>Further requirements in Attachment #1 to Appendix B-2</p> <p>Title 17, CCR, §54342(a)(6); Title 17, CCR §§56710-56756.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Day Habilitation - Day Program	Behavior Management Program			<p>Further requirements in Attachment #1 to Appendix B-2</p> <p>Title 17, CCR, §54342(a)(14); Title 17, CCR, §56710-56756.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Day Habilitation - Day Program	Independent Living Program			<p>Further requirements in Attachment #1 to Appendix B-2</p> <p>Title 17, CCR, §54342(a)(35); Title 17, CCR, §56710-56756.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Day Habilitation - Day Program	Infant Development Program	Health and Safety Code §1500-1567.8; Welfare and Institutions Code, §4693		<p>Further requirements in Attachment #1 to Appendix B-2</p> <p>Title 17, CCR, §54342(a)(37); Title 17, CCR, §56710-56734.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Day Habilitation - Day Program	Social Recreation Program			<p>Further requirements in Attachment #1 to Appendix B-2</p> <p>Title 17, CCR, §54342(a)(74); Title 17, CCR, §56710-56756.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Day Habilitation	Independent Living Specialist			<p>Further requirements in Attachment #1 to Appendix B-2</p> <p>Title 17, CCR, §54342(a)(36)</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Day Habilitation - Supplemental Day Services Program Support	Individual			<p>Further requirements in Attachment #1 to Appendix B-2</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
Day Habilitation	Art Therapist			<p>Title 17, CCR, §54342(a)(7).</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. Current registration issued by the American Art Therapy Association. See Attachment #2 to Appendix B-2</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Day Habilitation	Dance Therapist			Title 17, CCR, §54342(a)(19) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. Current registration issued by the American Dance Therapy Association. See Attachment #2 to Appendix B-2
Day Habilitation	Music Therapist			Title 17, CCR, §54342(a)(49) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. Possesses a valid registration issued by the National Association for Music Therapy. See Attachment #2 to Appendix B-2.
Day Habilitation	Recreational Therapist		Certification issued by either the National Council for Therapeutic Recreation Certification or the California Board of Recreation and Park Certification.	Title 17, CCR, §54342(a)(65) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Day Habilitation - Specialized Recreational Therapy	Agency; Recreational Therapist Equestrian Therapy; Instructor	Credentialed and/or licensed as required by the State	Equestrian therapy providers shall also possess a current accreditation and instructor certification with the North American Riding for the Handicapped Association	Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Day Habilitation - Creative Art Program	Agency	Business License, if required by law		Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326. See Attachment #2 to Appendix B-2.
Day Habilitation	Developmental Specialist			Further requirements in Attachment #1 to Appendix B-2. Title 17, CCR, §54342(a)(22). Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326. See Attachment #2 to Appendix B-2.
Day Habilitation	Driver Trainer - Individual	Valid California driver's license.	Current certification by the California Department of Motor Vehicles as a driver instructor.	Title 17, CCR, § 54342(a)(25) Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326. See Attachment #2 to Appendix B-2.
Day Habilitation - Special Olympics	Individual			Knowledge and training of appropriate sports. Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Supported Employment	Community Rehabilitation Program	Federal/State Tax Exempt Letter	Certification by Department of Rehabilitation and/or Commission on Accreditation for Rehabilitation Facilities	Welfare and Institutions Code, §4850 through 4867 Further requirements in Attachment#1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326. See Attachment #2 to Appendix B-2.
Pre-Vocational Services	Community Rehabilitation Program	Federal/State Tax Exempt Letter	Title 9, CCR, §7336 Certification by Department of Rehabilitation and/or Commission on Accreditation for Rehabilitation Facilities	Welfare and Institutions Code, §4850 through 4867 Further requirements in Attachment#1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326. See Attachment #2 to Appendix B-2.
Day Habilitation - Day Program	In-Home Day Program			Further requirements in Attachment#1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326. See Attachment #2 to Appendix B-2.
ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS:				
Environmental Accessibility Adaptations	Appropriate for the type of adaptation to be completed	Business License as appropriate		Further requirements in Attachment#1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
SKILLED NURSING:				
Skilled Nursing	Individual Registered Nurse Provider	Business & Professions Code §§2725-2742 Title 22, CCR §51067		Title 17, CCR, § 54342(a)(66) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Skilled Nursing	Individual Licensed Vocational Nurse Provider	Business & Professions Code §§2859-2873.7 Title 22, CCR §51069		Title 17, CCR, § 54342(a)(46) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Skilled Nursing	Home Health Agency; Registered Nurse Licensed Vocational Nurse	Title 22, CCR, §§74600 et. seq. RN: Business & Professions Code §§2725-2742 Title 22, CCR, §51067 LVN: Business & Professions Code §§2859-2873.7 Title 22, CCR, §51069	Medi-Cal certification using Medicare standards, Title 22 CCR §51217	Title 17, CCR, §542342(a)(31) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
TRANSPORTATION:				
Transportation	Individual	Welfare and Institutions Code Section 4648.3; Title 17 CCR, §58520(b). Valid California driver's license		Title 17, CCR, §54342(a)(82) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Transportation	Business Entities	Welfare and Institutions Code Section 4648.3 Company; Current business license.		Companies: Title 17, CCR, § 54342(a)(84) Brokers: Title 17, CCR, § 54342(a)(83) Additional Component: Title 17, CCR, § 54342(a)(80) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Transportation	Public Transit Authority	Welfare and Institutions Code Section 4648.3 Appropriate business license.		Title 17, CCR §542342(a)(86) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Transportation	Transportation Assistant	Welfare and Institutions Code Section 4648.3 Title 17 CCR, §58520(b).		Title 17, CCR, §54342(a)(81) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
SPECIALIZED MEDICAL EQUIPMENT:				
Specialized Medical Equipment and Supplies	Durable Medical Equipment Dealer	Business License as appropriate		<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>DME Dealer: Title 17, CCR, §54342(a)(26).</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.</p>
CHORE SERVICES:				
Chore Services	Individual: As appropriate for the repair services to be done.			<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.</p>
PERSONAL EMERGENCY RESPONSE SYSTEMS:				
Personal Emergency Response Systems	Appropriate for the system to be purchased.	Business License as appropriate		<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
FAMILY TRAINING:				
Family Training - Counseling Services	Marriage, Family, Child Counselor; Clinical Social Worker	Business and Professions Code §§4980-4984.9; Business and Professions Code §§4996-4997		Title 17, CCR, §54342(a)(18) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
Family Training - Parenting Support Services	Agency, county parenting program, or counseling center.	Business License as appropriate		Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
Family Training - Individual or Family Training Services	Individual; Agency; teacher; or family counselor.	Business License as appropriate		Further requirements in Attachment #1 to Appendix B-2. Qualifications and training as appropriate in the field being offered; or qualifications and training of staff per agency guidelines. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
<i>Family Training—Travel Reimbursement</i>	<i>Travel Agency; Individual Service Provider</i>	<i>Business License as appropriate; Valid California Driver's license as appropriate</i>		<i>Further requirements in Attachment #1 to Appendix B-2.</i> <i>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.</i>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
ADULT RESIDENTIAL CARE:				
Adult Foster Care	Family Home Agency/Adult Family Home <i>Family Teaching Home</i>		Adult Family Home: Title 17, CCR, §§56075-56088	Further requirements in Attachment #1 to Appendix B-2. FHA: Title 17, CCR, §§56075-56099; Title 17, CCR, §54342(a)(28) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Assisted Living	Residential Facility; Adult Residential Facility, or Residential Facility for the Elderly	Health and Safety Code §§1500-1569.87; ARF: Title 22, CCR, §§85000-85092; RCFE: Title 22, CCR, §§87100-87730		Further requirements in Attachment #1 to Appendix B-2. Title 17, CCR, §54342(a)(67) and (a)(69) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Assisted Living - Supplemental Residential Program Support	Adult Residential Facility Staff	Health and Safety Code §§1500-1569.87; ARF: Title 22, CCR, §§85000-85092		Further requirements in Attachment #1 to Appendix B-2 Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See attachment #2 to Appendix B-2.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Assisted Living: Out-of-State Residential Treatment Program	Residential facilities for adults	Licensed, as required by appropriate State law.		Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
Assisted Living - Geriatric Facility	Residential Facility for the elderly	Health and Safety Code §§1500-1569.87; RCFE: Title 22, CCR, §§87100-87730		Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
Assisted Living – DSS Licensed – Specialized Residential Facility – Adult/Elderly	Adult Residential Facility <u>Adult Residential Facility for Persons With Special Health Care Needs</u>	Health and Safety Code §§1500-1569.87; ARF: Title 22, CCR, §§85000-85092		Further requirements in Attachment #1 to Appendix B-2. <u>Welfare and Institutions Code Section 4684.50</u> Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
Supported Living	Supported Living	Business license as appropriate		Further requirements in Attachment #1 to Appendix B-2. Title 17, CCR, §§54349; 58600-58680. See Attachment #2 to Appendix B-2.
Supported Living	Individual			Further requirements in Attachment #1 to Appendix B-2. Title 17, CCR, §§54349; 58600-58680. Attachment #2 to Appendix B-2.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
OTHER WAIVER SERVICES:				
VEHICLE MODIFICATION AND ADAPTATION:				
Vehicle Modification and Adaptations	As appropriate for the adaptations to be done.	Business License as appropriate		<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326.</p> <p>Services in accordance with industry standards, Title 9, CCR, §§7165(d)(1)-(5). See Attachment #2 to Appendix B-2.</p>
COMMUNICATION AIDES:				
Communication Aides	Facilitators; Readers and reading services			<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Qualifications and training as appropriate.</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.</p>
Communication Aides	Interpreter			<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Title 17, CCR, § 54342(a)(44).</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Communication Aides	Translator			Further requirements in Attachment #1 to Appendix B-2. Title 17, CCR, § 54342(a)(79). Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
CRISIS INTERVENTION:				
Mobile Crisis Intervention	Behavior Analyst; <u>Assistant Behavior Analyst</u> Behavior Management Consultant; Psychologist; Psychiatric Technician, or <u>Psychiatrist</u>	Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff assigned to the team.	Behavior Analyst <u>and Assistant Behavior Analyst</u> (if required): Certification by the Behavior Analyst Certification Board	Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
Crisis Intervention – Facility Services	Adults: Adult Residential Facility; Family Home Agency/ Adult Family Homes; Residential Care Facility for the Elderly Children: Small Family Homes; Group Homes; Foster Family Homes; Foster Family Agency/ Certified Family Homes.	Health and Safety Code §§1500-1569.87; ARF: Title 22, CCR §§85000-85092; RCFE: Title 22, CCR, §§87100-87730; SFH: Title 22, CCR, §§83000-83088; GH: Title 22, CCR, §§84000-84369 FFH: Title 22, CCR, §§87000-87088; FFA: Title 22, CCR, §§89200-89587.1		Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
NUTRITIONAL CONSULTATION:				
Nutritional Consultation	Dietitian/Nutritionist		Dietician: Valid registration as a member of the American Dietetic Association	<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Title 17, CCR, § 54342(a)(24)</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>
BEHAVIOR INTERVENTION:				
Behavior Intervention	Psychiatrist	Business and Professions Code, Division 2, Chapter 5, commencing at Section 2000.		<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Title 17, CCR, § 54342(a)(64)</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326 and meets the conditions of participation in Medi-Cal as established in the California Medicaid State Plan. See Attachment #2 to Appendix B-2.</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Behavior Intervention	Behavior Management Assistant: Psychology Assistant	Business and Professions Code §2913		<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Title 17, CCR, § 54342(a)(12)</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326, and meets conditions of participation in Medi-Cal as established in the California Medicaid State Plan. See Attachment #2 to Appendix B-2</p>
Behavior Intervention	Behavior Management Consultant: Psychologist	Business and Professions Code, §2940-2948		<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Title 17, CCR, § 54342(a)(13)</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326, and meets conditions of participation in Medi-Cal as established in the California Medicaid State Plan. See Attachment #2 to Appendix B-2</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Behavior Intervention	Behavior Management Consultant: Licensed Clinical Social Worker	Business and Professions Code §4996-4996.2		<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Title 17, CCR, § 54342(a)(13)</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326, and meets conditions of participation in Medi-Cal as established in the California Medicaid State Plan. See Attachment #2 to Appendix B-2</p>
Behavior Intervention	Behavior Management Consultant: Marriage, Family, Child Counselor	Business and Professions Code §4980-4984.7		<p>Title 17, CCR, § 54342(a)(13)</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326, and meets conditions of participation in Medi-Cal as established in the California Medicaid State Plan. See Attachment #2 to Appendix B-2</p>
Behavior Intervention	Behavior Management Assistant: Associate Licensed Clinical Social Worker	Business and Professions Code, §4996.18		<p>Further requirements in Attachment #1 to Appendix B-2.</p> <p>Title 17, CCR, § 54342(a)(12)</p> <p>Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2</p>

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Behavior Intervention	Registered Nurse - (Psychiatric)	Business and Professions Code, §§2732-2736		Further requirements in Attachment #1 to Appendix B-2. Title 9, CCR, §627; Title 17, CCR, § 54342(a)(66) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
Behavior Intervention	Licensed Psychiatric Technician	Business and Professions Code §4500 et. seq.		Title 17, CCR, § 54342(a)(63) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Behavior Intervention	Clinical Psychologist	Business and Professions Code, §§800-809.9; §§2725-2742. Health and Safety Code, §1316.5		Title 17, CCR, § 54342(a)(17) Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2
Behavior Intervention - Client/Parent Support Behavior Intervention Training	Behavior Analyst, <u>Assistant Behavior Analyst</u> Behavior Management Consultant; Psychologist; or Psychiatric Technician.	Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff.	Behavior Analyst <u>and Assistant Behavior Analyst</u> (if required): Certification by the Behavior Analyst Certification Board.	Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Behavior Intervention - Supplemental Program Support	Agency; individual.	Business License as appropriate		Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.
Specialized Therapeutic Services				
Oral Health Services for Maladaptive Behaviors/Social-Emotional Behavior Impairments Due to/Associated with a Developmental Disability Physical Health	Dentist Dental Hygienist Psychologist Marriage and Family Therapist Social Worker Chemical Addiction Counselor Physician/Surgeon Speech Therapist Occupational Therapist Occupational Therapy Assistant Physical Therapist Physical Therapy Assistant Respiratory Therapist RN LVN Nurse Practitioner	Business and Professions Code: Dentist: §1628- 1635 Dental Hygienist: §1766 & 1768 Psychologist: §2940-2946 Marriage & Family Therapist: §4986.2 Social Worker: §4996.1 – 4996.2 Physician/Surgeon: §2080-2096 Speech Therapist: §2532.1-2532.6 Occupational Therapist and Assistant: §2570.6 Physical Therapist: §2636.5 Physical Therapy Assistant: §2655 Respiratory Therapist: §3733-3737 RN § 2725-2742 LVN § 2859-2873.7 Nurse Practitioner: §2834-2837	Chemical Addiction Counselor - certified in accordance with <u>Title 9 CCR § 9846-13075 counseling certification organizations</u> Physicians and Surgeons: Business and Professions Code, §2080-2085	Further requirements in Attachment #1 to Appendix B-2. Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2.

SERVICE	PROVIDER TYPE	LICENSE	CERTIFICATION	OTHER STANDARD
Transition/Set up Expenses				
Transition/Set Up Expenses	Public Utility Agency Retail and Merchandise Company Health and Safety agency Individual (landlord, property management) Moving Company	Business License appropriate for the service/item being provided.		Further requirements in Attachment#1 to Appendix B-2. Generic Agencies: Title 17, CCR, §§54316 Public Utilities Code §2281 Vendored by the regional center in accordance with Title 17, CCR, §§54310 and 54326. See Attachment #2 to Appendix B-2

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B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICES

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3 - KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES**KEYS AMENDMENT ASSURANCE:**

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- Home and community-based services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- A copy of the standards applicable to each type of facility identified above is maintained by the California Department of Social Services, Community Care Licensing Division. In addition, the Department of Developmental Services is the designated agency responsible for establishing, maintaining and ensuring enforcement of standards for Adult Family Home Agencies and the family homes (non-medical residential facilities) they approve for adults with developmental disabilities.

ATTACHMENT #1 TO APPENDIX B-2

ADDITIONAL PROVIDER QUALIFICATIONS AND REQUIREMENTS

ADDITIONAL PROVIDER QUALIFICATIONS

Homemaker - Individual

Individual providers of homemaker services shall possess the following minimum qualifications:

1. The ability to maintain, strengthen, and safeguard the care of individuals in their homes; and
2. Demonstrated dependability and personal integrity.

Homemaker - Service Agency

Agencies who employ, train, and assign personnel to provide homemaker services shall possess the following minimum requirements:

1. An appropriate business license as required by the local jurisdiction where the agency is located; and
2. Personnel who meet the minimum qualifications for individual providers of homemaker services.

Home Health Aide

An individual employed by a licensed and Medi-Cal certified home health agency who has completed a training program approved by the Department of Health Services which meets the requirements of 42 CFR 484.36(b) or (e), and is certified pursuant to California Health and Safety Code § 1736.1.

Respite -- Adult Day Care Facility

[22 CCR 80064 and 22 CCR 82064]

The administrator shall have the following qualifications:

1. Attainment of at least 18 years of age.
2. Knowledge of the requirements for providing the type of care and supervision needed by clients, including ability to communicate with such clients.
3. Knowledge of and ability to comply with applicable law and regulation.
4. Ability to maintain or supervise the maintenance of financial and other records.
5. Ability to direct the work of others, when applicable.
6. Ability to establish the facility's policy, program and budget.

7. Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff, if applicable to the facility.

and

1. A baccalaureate degree in psychology, social work or a related human services field and a minimum of one year experience in the management of a human services delivery system; or
2. Three years experience in a human services delivery system including at least one year in a management or supervisory position and two years experience or training in one of the following:
 - A. Care and supervision of participants in a licensed adult day care facility, adult day support center or an adult day health care facility.
 - B. Care and supervision of one or more of the categories of persons to be served by the center.

The licensee must make provision for continuing operation and carrying out of the administrator's responsibilities during any absence of the administrator by a person who meets the qualification of an administrator.

Respite Care Facility -- Residential Care Facility - Small Family Home

[17 CCR 54342(a)(67)]

Valid community care facility license for a Small Family Home as required by Health and Safety Code, Sections 1500 through 1567.8

Administrator Requirements - Applies to all community care facilities:

- Criminal Record Clearance;
- Medical assessment including TB clearance;
- Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients;
- Knowledge of and ability to comply with applicable laws and regulations;
- Ability to maintain or supervise the maintenance of financial and other records;
- Ability to direct the work of others;
- Ability to establish the facility's policy, program and budget;
- Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff

Licensee/Administrator Qualifications

- Child Abuse Index Clearance;
- At least 18 years of age;
- Documented education, training, or experience in providing family home care and supervision appropriate to the type of children to be served. The amount of units or training hours are not specified. The following are examples of acceptable

education or training topics. Programs which can be shown to be similar are accepted:

- Child Development
- Recognizing and/or dealing with learning disabilities
- Infant care and stimulation
- Parenting skills
- Complexities, demands and special needs of children in placement
- Building self esteem, for the licensee or the children
- First aid and/or CPR
- Record keeping
- Bonding and/or safeguarding of children's property
- Licensee rights and grievance process
- Licensing and placement regulations
- Rights and responsibilities of family home providers

Respite Care Facility -- Residential Care Facility - Adult Residential Care or Residential Care Facility for the Elderly

Valid community care facility license for an Adult Residential Facility or a Residential Care Facility for the Elderly as required by Health and Safety Code, Sections 1500 through 1569.8.

Administrator Requirements - Applies to all community care facilities:

- Criminal Record Clearance;
- Medical assessment including TB clearance;
- Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients;
- Knowledge of and ability to comply with applicable laws and regulations;
- Ability to maintain or supervise the maintenance of financial and other records;
- Ability to direct the work of others;
- Ability to establish the facility's policy, program and budget;
- Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff.

Administrator Qualifications

- At least 21 years of age;
- High school graduation or a GED;
- Complete a program approved by CCLD that consists of 35 hours of classroom instruction
 - 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities;
 - 3 hrs. in business operations;
 - 3 hrs. in management and supervision of staff;

- 5 hrs. in the psychosocial needs of the facility residents;
- 3 hrs. in the use of community and support services to meet the resident's needs;
- 4 hrs. in the physical needs of the facility residents;
- 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents;
- 4 hrs. on admission, retention, and assessment procedures;
- Pass a standardized test, administered by the department with a minimum score of 70%.

For a capacity of 7 - 15 clients -

- 1 year work experience in residential care.

Respite -- Community Recreational Setting

Community recreational program providers shall possess the following minimum qualifications:

1. Ability to perform the functions required by the individual plan of care;
2. Demonstrated dependability and personal integrity;
3. Willingness to pursue training as necessary, based upon the individual consumer's needs.

Respite -- Camp

Camping Services [17 CCR 54342 (a)(15)]

A vendor which is either:

- A. A day camp which:
 1. Provides a creative experience in outdoor living for a limited period of hours per day and days per year; and
 2. Contributes to the individual's mental, physical, and social growth by using the resources of the natural surroundings; or
- B. A residential camp which provides:
 1. A creative experience in outdoor living on a 24-hour per day basis for a limited period of time;
 2. Services which use the resources of the natural surroundings to contribute to the individual's mental, physical, and social growth; and
 3. Other consistent services.

Staff possess demonstrated competence to supervise safety of camp activities.
[17 CCR 54342 (a)(15)(B)]

Residential Camps:

1. Valid fire clearance issued by the California State Fire Marshal, city fire department, or local fire district;
2. Comply with the requirements of Title 17, Sections 30700 through 30753;
3. Have a registered nurse on staff at all hours of operation; or
4. Have a waiver issued by the appropriate agency if any of the requirements specified in 1 through 3 above are not met.

Residential Habilitation for Children Services - Small Family Home

[17 CCR 54342 (a)(68)]

Valid community care facility license for a Small Family Home as required by Health and Safety Code, Section 1500 through 1567.8

Administrator Requirements - Applies to all community care facilities:

- Criminal Record Clearance;
- Medical assessment including TB clearance;
- Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients;
- Knowledge of and ability to comply with applicable laws and regulations;
- Ability to maintain or supervise the maintenance of financial and other records;
- Ability to direct the work of others;
- Ability to establish the facility's policy, program and budget;
- Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff.

Licensee/Administrator Qualifications

- Child Abuse Index Clearance;
- At least 18 years of age;
- Documented education, training, or experience in providing family home care and supervision appropriate to the type of children to be served. The amount of units or supervision appropriate to the type of children to be served. The amount of units or training hours are not specified. The following are examples of acceptable education or training topics. Programs which can be shown to be similar are accepted:
 - Child Development;
 - Recognizing and/or dealing with learning disabilities;
 - Infant care and stimulation;
 - Parenting skills;
 - Complexities, demands and special needs of children in placement;
 - Building self esteem, for the licensee or the children;
 - First aid and/or CPR;
 - Record keeping;
 - Bonding and/or safeguarding of children's property;
 - Licensee rights and grievance process;
 - Licensing and placement regulations;
 - Right and responsibilities of family home providers.

Residential Habilitation for Children Services - Out of State Residential Treatment Program

Provide an out-of-state residential program for regional center consumers. Department approval is required per the Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code, Section 4519.

DSS Licensed - Specialized Residential Facility - Children

A regional center shall classify a vendor as a DSS Licensed-Specialized Residential Facility provider if the vendor operates a residential care facility licensed by the Department of Social Services (DSS) for individuals with developmental disabilities who require 24 hour care and supervision and whose needs cannot be appropriately met within the array of other community living options available.

Primary services provided by a DSS Licensed-Specialized Residential Facility may include personal care and supervision services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law) and therapeutic social and recreational programming, provided in a home-like environment. Incidental services provided by a DSS Licensed-Specialized Residential Facility may include home health care, physical therapy, occupational therapy, speech therapy, medication administration, intermittent skilled nursing services, and/or transportation, as specified in the IPP. This vendor type provides 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and the provision of supervision and direct care support to ensure the consumers' health, safety and well-being. Other individuals or agencies may also furnish care directly, or under arrangement with the DSS Licensed-Specialized Residential Facility, but the care provided by these other entities must supplement the care provided by the DSS Licensed-Specialized Residential Facility and does not supplant it.

Regional Center monitoring of the DSS Licensed-Specialized Residential Facility shall be in accordance with the applicable state laws and licensing regulations, including Title 17, and the regional center admission agreement. Payment for services in a DSS Licensed-Specialized Residential Facility must be made pursuant to Title 17, Section 56919 (a), after the regional center obtains approval from the Department for payment of the prevailing rate or, pursuant to Welfare & Institutions Code, Section 4648 (a)(4), the regional center may contract for the provision of services and supports for a period of up to three years, subject to the availability of funds.

Residential Habilitation for Children Services - Supplemental Residential Program Support

Agencies who employ, train, and assign personnel to provide program support services in a residential setting shall possess the following minimum requirements:

1. An appropriate business license as required by the local jurisdiction where the agency is located; and
2. Staff who meet the following minimum qualifications:
 - a. The ability to perform the functions required in the individual plan of care;
 - b. Demonstrated dependability and personal integrity; and
 - c. Willingness to pursue training as necessary, based upon the individual's needs.

A regional center shall classify a vendor as a Supplemental Residential Program Support provider if the vendor provides, or obtains, time limited, supplemental staffing in excess of the amount required by regulation. Supplemental Residential Program Support is designed to implement an objective in the consumer's IPP and allow the consumer to remain in their current residential environment. Supplemental Residential Program Support services include, but are not limited to: assistance and training in skills for activities in daily living and in socially appropriate skills to replace (and serve the same function/purpose as) challenging behavior.

Staff are hired by the residential provider. The provider is already vendored by the regional center and licensed by the State.

Day Habilitation -- Mobility Trainer - Service Agency

Agencies who employ, train, and assign personnel to teach individuals how to use public transportation or other modes of transportation which will enable them to move about the community independently, shall possess the following minimum requirements:

1. Appropriate business license as required by local jurisdiction; and
2. Personnel who possess the skill, training or education necessary to teach individuals how to use public transportation or other modes of transportation which enable them to move about the community independently including: previous experience working with individuals with developmental disabilities and awareness of associated problems, attitudes and behavior patterns, a valid California Driver's license and current insurance, ability to work independently with minimal supervision according to specific guidelines, flexibility and adaptive skills to facilitate individual consumer needs.

Day Habilitation -- Mobility Trainer - Specialist

Individuals who teach individuals how to use public transportation or other modes of transportation which enable them to move about the community independently, shall possess the following minimum requirements:

1. Previous experience working with individuals with developmental disabilities and awareness of associated problems, attitudes and behavior patterns;
2. A valid California Driver's license and current insurance;
3. Ability to work independently, flexibility and adaptive skills to facilitate individual consumer needs.

Day Habilitation -- Adaptive Skills Trainer

Master's degree in education, psychology, counseling, nursing, social work, applied behavior analysis, behavioral medicine, speech and language or rehabilitation; and at least one year of experience in the designing and implementation of adaptive skills training plans.

Day Habilitation -- Community Integration Services

1. **Personal Assistance:**
Person provides personal assistance and support to ambulatory and non-ambulatory consumers.
2. **Socialization Training Program:**
Program provides socialization opportunities for school age developmentally disabled persons.
3. **Community Integration Training Program:**
Program designed to provide training and skill development in conflict resolution, community participation including knowledge of, and access to community resources, interpersonal relationships, and personal habits necessary to obtain and retain employment. Program directors must have at least a bachelor's degree. Direct service workers may be qualified by experience.
4. **Community Activities Support Services:**
Provides support on a time-limited basis to accomplish various activities for consumers.

Day Habilitation -- Day Program

1. Activity Center [17 CCR 54342 (a)(1)]
Vendor which provides training in a center based and/or natural environments in self-advocacy, employment training, community integration and/or self-care.

[17 CCR 56710-56756]
Requires written program design, consumer entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills. Staff to consumer ratio = 1:8.
2. Adult Developmental Center [17 CCR 54342 (a)(6)]
Vendor which provides training in a center based and/or natural environments in self-advocacy, employment training, community integration and/or self-care.

[17 CCR 56710-56756]
Requires written program design, consumer entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills. Staff to consumer ratio = 1:4.
3. Behavior Management Program [17 CCR 54342 (a)(14)]
Vendor which provides training in a center based and/or natural environments in self-advocacy, employment training, community integration and/or self-care.

[17 CCR 56710-56756]
Requires written program design, consumer entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills. Staff to consumer ratio = 1:3.
4. Independent Living Program [17 CCR 54342 (a)(35)]
Vendor which provides training in a setting which is not center-based and includes cooking, cleaning, shopping in natural environments, menu planning, meal preparation, money management including check cashing and purchasing activities, use of public transportation in natural environments, personal health and hygiene, self-advocacy training, independent recreation and participation in natural environments, use of medical and dental services, as well as other community resources, community resource awareness such as police, fire, or emergency help, and home and community safety.

Vendor may, in lieu of above, provide the supports necessary for a consumer to maintain a self-sustaining independent living situation in the community.

[17 CCR 56710-56756]

Requires written program design, consumer entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills. Staff to consumer ratio = 1:1 - 1:3.

5. Social Recreation Program [17 CCR 54342 (a)(74)]
Vendor which provides community integration and self-advocacy training as they relate to recreation and leisure pursuits conducted in a center-based and/or natural environments.

[17 CCR 56710-56756]

Requires written program design, consumer entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills. Staff to consumer ratio = 1:10.

Day Habilitation - Independent Living Specialist

Possesses the skill, training, or education necessary to teach consumers to live independently and/or to provide the supports necessary for the consumer to maintain a self-sustaining, independent living situation in the community, such as one year experience providing services to adults with developmental disabilities in a residential or non-residential setting and possession of at least a two-year degree in a subject area related to skills training and development of program plans for individuals with developmental disabilities.

Day Habilitation - Supplemental Day Services Program Support

A regional center shall classify a vendor as a Supplemental Day Services Program Support provider if the vendor provides or obtains, time limited, supplemental staffing in excess of the amount required by regulation. Supplemental Day Services Program Support is designed to implement an objective in the consumer's IPP and allow the consumer to remain in a known and stable day program/employment environment. Supplemental Day Services Program Support services include, but are not limited to: assistance and training in skills for activities of daily living and in socially appropriate skills to replace (and serve the same function/purpose as) challenging behavior.

Day Habilitation - Specialized Recreation Therapy

Agency must employ Recreation Therapists as well as aides or other employees to provide this service. Vendors shall be credentialed and/or licensed by the State of California in order to practice in the field of therapy being offered. By December 31, 2001, Equestrian Therapy providers shall also possess a current program accreditation and instructor certification with the North American Riding for the Handicapped Association.

Day Habilitation - Creative Art Program

Create self-expression through art, which includes art classes. Program may be center-based or be provided in the consumer's residence. Provider qualifications include:

Program Director: Equivalent of a high school diploma and experience with persons with developmental disabilities.

Direct Care Staff: Must have artistic experience as demonstrated through a resume.

Day Habilitation - Developmental Specialist

Possesses a valid certification by an accredited hospital as having successfully completed a one-year developmental specialist training program; or possesses a Master's degree in Developmental Therapy from an accredited college or university.

Day Habilitation - Supported Employment Services

Must be a community nonprofit agency.

Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF, the Rehabilitation Accreditation Commission within four years of providing services.

Day Habilitation - Prevocational Services

Must be a community nonprofit agency.

Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF, the Rehabilitation Accreditation Commission within four years of providing services.

Day Habilitation - In-Home Day Program

Providers must have a service design by the regional center. Providers may include employees of vendored community-based day, prevocation, or vocational programs. The vendor provides day program services to consumers who are unable to attend day programs outside their homes because of medical conditions which prevent travel to outside programs. In-home day programs are designed to allow the consumer to remain in a stable day program environment. In-home day program services include a variety of activities designed to meet consumer needs from activity center programs to vocational activities which can be completed from home. An in-home day program must be vendored with the regional center and have a provision for an annual assessment process to ensure consumer participation in this type of program remains appropriate. This can be done in conjunction with the regional center annual review.

Environmental Accessibility Adaptations

Individuals or agencies who provide environmental modification services shall have a current license, certification, or registration with the State of California as appropriate for the type of modification being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Specialized Medical Equipment and Supplies

Providers of specialized medical equipment and supplies shall have a current license, certification, or registration with the State of California as appropriate for the type of equipment or supplies being purchased. Providers shall also be authorized by the manufacturer to install, repair, and maintain such systems if such a manufacturer's authorization program exists.

The provider shall also possess a current license to do business issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Chore Services - Individual

Individual chore services providers shall possess the following minimum qualifications:

1. The ability to perform the functions required in the individual plan of care;
2. Demonstrated dependability and personal integrity.

Personal Emergency Response Systems

Providers of personal emergency response systems shall have a current license, certification, or registration with the State of California as appropriate for the type of system being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Providers shall be competent to meet applicable standards of installation, repair, and maintenance of emergency response systems. Providers shall also be authorized by the manufacturer to install, repair, and maintain such systems if such a manufacturer's authorization program exists.

Providers of human emergency response services shall possess or have employed persons who possess current licenses, certifications or registrations as necessary and required by the State of California for persons providing personal emergency response services.

Family Training - Parenting Support Services - Agency

Agency staff must include:

1. Psychologist with Ph.D. in clinical, developmental, or educational psychology with experience that qualified him/her to counsel couples and families, supervise birthing and parenting training and supervise the parenting specialists.
2. Parenting Specialists must have a Master's degree and/or relevant professional experience as a birthing educator. Experience in developmental disabilities required as well as experience in parent education and/or clinical work pertaining to pregnancy and infancy.

Services usually provided through a county parenting program or an agency such as an adult program, or counseling center.

Family Training - Individual or Family Training Services

A regional center shall classify a vendor as an Individual or Family Training provider if the vendor provides or obtains training services to consumers and/or family members as necessary to implement an objective in the individual's IPP including, but not limited to, training regarding prevention of sexual exploitation and parent and family support training to avert out-of-home placement. Individual or family training may include refresher training, as necessary to facilitate a safe, harmonious, and stable home, and may be provided in groups, e.g., seminars and symposiums, or on an individual basis. Vendors shall ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.

Director:

MA/MS/MSW/M.Ed. in human services or related field (preferred MFCC or LCSW eligibility). Extensive knowledge of children and adolescents with disabilities and their families as well as available resources and services in the community designed to meet their diverse needs. Background in family issues, advocacy, support networks, and community building.

Social Workers:

Proof of MA/MS in human services related area or a combination of practical experience and education in accordance with community care licensing regulations. Minimum of two years experience working/living with individuals with disabilities, preferably in a home or community-base setting, knowledge of needs and capacities of children with severe behavioral challenges, knowledge of resources for families of children with severe disabilities, valid CPR and First Aid training.

Family Training—Travel Reimbursement

~~***A regional center shall classify a vendor eligible for travel reimbursement if travel services, e.g., travel agency services, tickets, per diem, and lodging costs are incurred while implementing provisions related to a consumer's Individual Program Plan (IPP) and if the vendor is:***~~

~~***A. A travel agency and operates a business for the purpose of providing travel services, tickets, and travel vouchers, or***~~

~~***B. A person or service provider authorized by the regional center to recover travel costs, per diem, and lodging.***~~

~~***Any individual that provides vehicular transportation shall:***~~

~~***1. Possess a driver's license which is valid in California; and***~~

~~***2. Have evidence of maintenance of adequate insurance coverage pursuant to Welfare and Institutions Code, Section 4648.3.***~~

Adult Residential Care - Adult Foster Care - Family Home Agency

[17 CCR 56075 - 56099]

Requires response to RFA, program design, staff training, fingerprints, and criminal history check. FHA staff shall have education in fields of social work, psychology, education or related area, experience working or living with persons with developmental disabilities, experience and training in program management, fiscal management and organizational development. Approved homes also require criminal record check.

Adult Residential Care - Assisted Living - Adult Residential Facility or Residential Care Facility for the Elderly, or Geriatric Facility

Valid community care facility license for an Adult Residential Facility or a Residential Care Facility for the Elderly by Health and Safety Code, Section 1500 through 1569.8.

Administrator Requirements - Applies to all community care facilities:

- Criminal Record Clearance;
- Medical assessment including TB clearance;
- Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients;
- Knowledge of and ability to comply with applicable laws and regulations;
- Ability to maintain or supervise the maintenance of financial and other records;
- Ability to direct the work of others;
- Ability to establish the facility's policy, program, and budget;
- Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff.

Administrator Qualifications:

- At least 21 years of age;
- High school graduate or a GED;
- Complete a program approved by CCLD that consists of 35 hours of classroom instruction;
 - 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities;
 - 3 hrs. in business operations;
 - 3 hrs. in management and supervision of staff;
 - 5 hrs. in psychosocial needs of the facility residents;
 - 3 hrs. in the use of community and support services to meet the resident's needs;
 - 4 hrs. in the physical needs of the facility residents;
 - 5 hrs. in the use, misuse, and interaction of drugs commonly used by facility residents;
 - 4 hrs. on admission, retention, and assessment procedures;
 - Pass a standardized test administered by the department, with a minimum score of 70%.

For a capacity of 7 to 15 clients -

- 1 year work experience in residential care.

Adult Residential Care - Assisted Living - Supplemental Residential Program Support

Agencies who employ, train, and assign personnel to provide program support services in a residential setting shall possess the following minimum requirements:

1. An appropriate business license as required by the local jurisdiction where the agency is located; and
2. Staff who meet the following minimum qualifications:
 - a. The ability to perform the functions required in the individual plan of care;
 - b. Demonstrated dependability and personal integrity; and
 - c. Willingness to pursue training as necessary, based upon the individual's needs.

A regional center shall classify a vendor as a Supplemental Residential Program Support provider if the vendor provides, or obtains, time limited, supplemental staff in excess of the amount required by regulation. Supplemental Residential Program Support is designed to implement an objective in the consumer's IPP and allow the consumer to remain in their current residential environment. Supplemental Residential Program Support services include, but are not limited to: assistant and training in skills for

activities of daily living and in socially appropriate skills to replace (and serve the same function/purpose as) challenging behavior.

Staff are hired by the residential provider. The provider is already vendored by the regional center and licensed by the State.

Adult Residential Care - Assisted Living - Out of State Residential Treatment Program

Provide an out-of-state residential treatment program for regional center consumers. Department approval is required per the Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code, Section 4519.

DSS Licensed - Specialized Residential Facility- Adult/Elderly

A regional center shall classify a vendor, **such as Adult Residential Facilities for Persons with Special Health Care Needs**, as a DSS Licensed-Specialized Residential Facility provider if the vendor operates a residential care facility licensed by the Department of Social Services (DSS) for individuals with developmental disabilities who require 24 hour care and supervision and whose needs cannot be appropriately met within the array of other community living options available.

Primary services provided by a DSS Licensed-Specialized Residential Facility may include personal care and supervision services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law) and therapeutic social and recreational programming, provided in a home-like environment. Incidental services provided by a DSS Licensed-Specialized Residential Facility may include home health care, physical therapy, occupational therapy, speech therapy, medication administration, intermittent skilled nursing services, and/or transportation, as specified in the IPP. This vendor type provides 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and the provision of supervision and direct care support to ensure the consumers' health, safety and well-being. Other individuals or agencies, may also furnish care directly, or under arrangement with the DSS Licensed-Specialized Residential Facility, but the care provided by these other entities must supplement the care provided by the DSS Licensed-Specialized Residential Facility and does not supplant it.

Regional Center monitoring of the DSS Licensed-Specialized Residential Facility shall be in accordance with the applicable state laws and licensing regulations, including Title 17, and the regional center admission agreement. Payment for services in a DSS Licensed-Specialized Residential Facility must be made pursuant to Title 17, Section 56919 (a), after the regional center obtains approval from the Department for payment of the prevailing rate or, pursuant to Welfare & Institutions Code, Section 4648 (a)(4), the regional center may contract for the provision of services and supports for a period of up to three years, subject to the availability of funds.

Additional Requirements for Large Facilities Providing Assisted Living

In addition to the requirements established by the California Department of Social Services' Title 22 regulations and the Department of Developmental Services' Title 17 regulations, assisted living shall be provided in small, individualized settings that promote full integration into the surrounding community and promote individual empowerment, independence, and productivity. They will be in settings where living quarters are scattered in the community at large, or may be in arrangements similar to an apartment house or retirement community. They shall also respect an individual's rights and dignity by providing:

1. Bedrooms which are shared by no more than two individuals, with one person in a bedroom being preferred.
2. Common living areas that are conducive for interaction between residents, and residents and their guests.
3. Residents the opportunity to make decisions on their day-to-day activities in their home and in the community.
4. Services which meet the needs of each resident.
5. Residents the privacy necessary for personal hygiene, dressing, and being by themselves, if they choose.

All large facilities will be reviewed and approved by the Department of Developmental Services, the Department of Health Services, and the regional office of CMS before acceptance as a participating provider for this waiver.

Adult Residential Care - Supported Living - Supported Living Service

[17 CCR 58600 et. seq.]

Requires service design, staff appropriate to services rendered with skills to establish and maintain constructive and appropriate personal relationship with consumers, minimize risks of endangerment to health, safety, and well-being of consumers, perform CPR and operate 24-hour emergency response systems, achieve the intended results of services being performed and maintain current and valid licensure, certification, or registration as are legally required for the service. Also requires staff orientation and training in theory and practice of supported living services and consumer training in supported living services philosophy, consumer rights, abuse prevention and reporting, grievance procedures and strategies for building and maintaining a circle of support.

Vehicle Adaptations

Providers of vehicle adaptations shall have a current license, certification, or registration with the State of California as appropriate for the services being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the local jurisdiction within which the individual or agency is located.

Providers shall be competent to meet applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

Communication Aides - Facilitator

Providers who are facilitators shall have:

1. The ability to perform the functions identified in the individual plan of care; and
2. Demonstrated knowledge of the concerns and special needs of persons with developmental disabilities as related to the community; and
3. Sensitivity to the communication process between communication-impaired individuals and non-impaired individuals, and the needs of the persons involved in the process; and
4. The ability to maintain confidentiality.

Communication Aides - Reader

1. The ability to read aloud and to speak intelligibly in a language understood by the beneficiary;
2. Demonstrated knowledge of the concerns and special needs of persons with developmental disabilities as related to the community;
3. Sensitivity to the communication process between communication-impaired individuals and non-impaired individuals, and the needs of the persons involved in the process; and
4. The ability to maintain confidentiality.

Communication Aides - Interpreter

Providers of interpretation services shall have:

1. Proficiency in facilitating communication between hearing-impaired and hearing persons individually and/or in groups using American sign language and spoken language;
2. The equivalent of six months' experience providing interpreting services to hearing-impaired persons, or

Possession of at least one valid certificate issued by the Registry of Interpreters for the Deaf;

3. Demonstrated knowledge of the concerns and special needs of persons with developmental disabilities as related to the community;
4. Sensitivity to the communication process between hearing-impaired individuals and hearing individuals, and the needs of the persons involved in the process; and
5. The ability to maintain confidentiality.

Communication Aides - Translator

Providers of translation services shall have:

1. Fluency in both English and a language other than English;
2. The ability to read and write accurately in both English and a language other than English;
3. Demonstrated knowledge of the concerns and special needs of persons with developmental disabilities as related to the community; and
4. The ability to maintain confidentiality.

Crisis Intervention - Mobile Crisis Intervention - Mobile Crisis Intervention Teams

Providers of Mobile Crisis Intervention services shall be a team which is supervised by or has access to a licensed psychologist, psychiatrist, or Behavior Management Consultant.

Such teams shall be vendored specifically to provide mobile crisis intervention services. All members of the Mobile Crisis Intervention teams shall maintain a current license, registration or certification as appropriate for the professional services being provided. All unlicensed staff shall have at least one year of full-time experience in serving persons with developmental disabilities and shall have completed at least 40 hours of training in crisis intervention techniques prior to providing services.

Crisis Intervention -- Crisis Intervention Facility ServicesCrisis Intervention - Residential Care Facility

Crisis Intervention Facilities shall be an appropriate level residential care facility specifically vendored to provide emergency placement for individuals in need of intensive intervention services in order to maintain their preferred living options. Facilities shall have available staff who are supervised by or have access to a licensed psychologist, psychiatrist, or Behavior Management Consultant. In addition, a crisis intervention facility shall meet the following requirements:

Crisis Intervention - Residential Care Facility - Small Family Home

[17 CCR 54342 (a)(67)]

Valid community care facility license for a Small Family Home as required by Health and Safety Code, Sections 1500 through 1567.8

Administrator Requirements - Applies to all community care facilities:

- Criminal Record Clearance;
- Medical assessment including TB clearance;
- Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients;
- Knowledge of and ability to comply with applicable laws and regulations;
- Ability to maintain or supervise the maintenance of financial and other records;
- Ability to direct the work of others;
- Ability to establish the facility's policy, program, and budget;
- Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff.

Licensee/Administrator Qualifications

- Child Abuse Index Clearance;
- At least 18 years of age;
- Documented education, training, or experience in providing family home care and supervision appropriate to the type of children to be served. The

amount of units or training hours are not specified. The following are examples of acceptable education or training topics. Programs which can be shown to be similar are accepted:

- Child Development
- Recognizing and/or dealing with learning disabilities
- Infant care and stimulation
- Parenting skills
- Complexities, demands and special needs of children in placement
- Building self-esteem, for the licensee or the children
- First aid and/or CPR
- Record keeping
- Bonding and/or safeguarding of children's property
- Licensee rights and grievance process
- Licensing and placement regulations
- Rights and responsibilities of family home providers

Crisis Intervention - Residential Care Facility or Residential Care Facility for the Elderly

Valid community care facility license for an Adult Residential Facility or a Residential Care Facility for the Elderly as required by Health and Safety Code, Section 1500 through 1569.87

Administrator Requirements - Applies to all community care facilities:

- Criminal Record Clearance;
- Medical assessment including TB clearance;
- Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients;
- Knowledge of and ability to comply with applicable laws and regulations;
- Ability to maintain or supervise the maintenance of financial and other records;
- Ability to direct the work of others;
- Ability to establish the facility's policy, program, and budget;
- Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff.

Administrator Qualifications

- At least 21 years of age;
- High school graduation or a GED;
- Complete a program approved by CCLD that consists of 35 hours of classroom instruction;
 - 8 hrs. in law, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities;
 - 3 hrs. in business operations;
 - 3 hrs. in management and supervision of staff;
 - 5 hrs. in the psychosocial needs of the facility residents;

- 3 hrs. in the use of community and support services to meet the resident's needs;
- 4 hrs. in the physical needs of the facility residents;
- 5 hrs. in the use, misuse, and interaction of drugs commonly used by facility residents;
- 4 hrs. on admission, retention, and assessment procedures;
- Pass a standardized test, administered by the department with a minimum score of 70%.

For a capacity of 7 to 15 clients -

- 1 year work experience in residential care.

Nutritional Consultation - Dietician

Valid registration as a member of the American Dietetic Association.

Nutritional Consultation - Nutritionist

1. Possesses a Master's Degree in one of the following:
 - a. Food and Nutrition;
 - b. Dietetics; or
 - c. Public Health Nutrition; or
2. Is employed as a nutritionist by a county health department.

Behavior Intervention - Psychiatrist

Licensed as a physician and surgeon by the California Board of Medical Quality Assurance or the California Board of Osteopathic Examiners, and

Certified or eligible for certification by the American Board of Psychiatry and Neurology, or the American Osteopathic Board of Neurology and Psychiatry;

or

Licensed as a physician by the California Board of Medical Quality Assurance or the California Board of Osteopathic Examiners and has specialized training and/or experience in psychiatry.

Behavior Intervention - Behavior Management Assistant

[17 CCR 54342 (a)(12)]

Bachelor of Arts or Science and 12 semester units in applied behavior analysis and one year of experience in designing or implementing behavior modification intervention services; or

Bachelor of Arts or Science and two years experience in designing or implementing behavior modification intervention services.

Behavior Intervention - Behavior Management Assistant - Associate LCSW

[17 CCR 54342 (a)(12)]

Bachelor of Arts or Science and 12 semester units in applied behavior analysis and one year of experience in designing or implementing behavior modification intervention services; or

Bachelor of Arts or Science and two years experience in designing or implementing behavior modification intervention services.

Behavior Intervention - Behavior Management Consultant - Licensed Clinical Social Worker

[9 CCR §625]

In addition to a license as a clinical social worker, a psychiatric social worker shall have two years post master's experience in a mental health setting.

Behavior Intervention - Psychiatric Nurse

[9 CCR §627]

In addition to a license to practice as a registered nurse, a psychiatric nurse must possess a master's degree in psychiatric or public health nursing, and two years of nursing experience in a mental health setting. Additional post baccalaureate nursing experience in a mental health setting may be substituted on a year for year basis for the educational requirement.

Behavior Intervention - Client/Parent Support Behavior Intervention Training

Program serves consumers ages 4 years to 18 years (or those 3 years or younger deemed high risk for developmental delay). Program will be utilizing behavior modification techniques. The program will also intervene with the family and assists them in developing tools to work with their child. Ultimately, the family will be in a position to maintain the child in the home.

This program is not funded by the Department of Education because children and families will be served on an individual basis. However, the child's special education program will not be discontinued or altered.

Behavior Intervention - Supplemental Program Support

A regional center shall classify a vendor as a Supplemental Program Support provider if the vendor provides or obtains, time limited, supplemental staffing in excess of the amount required by regulation. Supplemental Program Support is designed to implement an objective in the consumer's IPP and allow the consumer to remain, or participate in, activities located in environments other than residential or day services. Supplemental program Support services include, but are not limited to: assistance and training in skills for activities of daily living and in socially appropriate skills to replace (and serve the same function/purpose as) challenging behavior.

Staff are usually from an agency such as an independent living specialist provider. The agency would already possess a business license as required by the State.

Specialized Therapeutic Services

Providers of Specialized Therapeutic Services must hold a valid State authorization to practice in the respective clinical field for which they are vendored AND, at minimum, have one year's experience working with persons with developmental disabilities.

~~Chemical Addiction Counselor – Specialized Therapeutic Services~~

~~Professionals with advanced or graduate degrees must have:~~

- ~~• A Master's Degree from an accredited health care training program;~~
- ~~• Three years of post-graduate, supervised experience providing direct health care services to those identified with an addictive disorder;~~
- ~~• A portfolio of clinical training with a minimum of 120 hours of training in basic counseling skills including assessment, interviewing and diagnosis, and a minimum of 60 hours of training in each area of specialization; and~~
- ~~• Three professional recommendations. At least one referent must be a supervisor who is personally familiar with the applicant's work and can document his or her health care experience.~~

~~Professionals with other degrees or without a degree must:~~

- ~~• Be over 18 years of age and have a high school diploma;~~
- ~~• Have five years of supervised experience providing direct health care services to those identified with an addictive disorder;~~
- ~~• Be presently employed or serving in a volunteer capacity in a social model program, or must have been employed or serving in a volunteer capacity in a social model program within the last full year prior to the filing date;~~
- ~~• Have a portfolio of clinical training that includes a minimum of 120 hours of training in basic counseling skills including assessment, interviewing and diagnosis, and a minimum of 60 hours of training in each area of specialization;~~
- ~~• Document a minimum of 150 hours of closely supervised on-the-job training in direct alcohol and/or other drug recovery services in a social model setting; and~~
- ~~• Have three professional recommendations. At least one referent must be a supervisor who is personally familiar with the applicant's work and can document his or her health care experience.~~

~~Only Chemical Addiction Counselors certified and credentialed by any the following organizations are authorized to provide services under this Waiver:~~

- ~~• California Association of Addiction Recovery Resources;~~
- ~~• California Association of Alcohol and Drug Educators;~~
- ~~• California Association of Alcoholism and Drug Abuse Counselors;~~
- ~~• California Association of Drinking Drivers Treatment Program;~~
- ~~• Forensic Addiction Counselors Team;~~
- ~~• American Academy of Providers in the Addictive Disorders; or~~
- ~~• Indian Alcoholism Commission of California, Inc.~~

ATTACHMENT #2 TO APPENDIX B-2

- [Title 17, California Code of Regulations, Section 54310, Vendor Application Requirements](#)
- [Title 17, California Code of Regulations, Section 54326, General Requirements for Vendors and Regional Centers](#)
- [Title 17, California Code of Regulations, Section 54342, Types of Services](#)
- [Title 17, California Code of Regulations, Section 54349, Vendorization - Supported Living Services](#)
- [Title 17, California Code of Regulations, Section 54351, Habilitation Services \(effective July 1, 2004\)](#)
- [Title 17, California Code of Regulations, Section 54344 **54355**, Vouchers](#)
- [Title 17, California Code of Regulations, Section 58612, Supported Living Service - Vendor Status Requirements](#)
- [Title 17, California Code of Regulations, Section 58614, Supported Living Service - Service and Support Components](#)
- [Title 17, California Code of Regulations, Section 58800, Habilitation Services Program \(effective July 1, 2004\)](#)

ATTACHMENT TO APPENDIX B-3

- [*Title 17, California Code of Regulations, Section 56076, Family Home Agency*](#)

and community-based services in order to remain in the community are included in this waiver: (check all that apply)

- (1) A special income level equal to:
 300% of the SSI Federal benefit (FBR)
 ___% of FBR, which is lower than 300% (42 CFR 435.236)
 \$___ which is lower than 300%
- (2) Aged, blind, and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)
- (3) Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324)
- (4) Medically needy without spenddown in 209(b) States (42 CFR 435.330).
- (5) Aged and disabled who have income at:
 a. 100% of the FPL.
 b. ___% which is lower than 100%
- (6) Other (include statutory reference only to reflect additional groups included under the State plan).
7. Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330).
8. Other (include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver).

All other mandatory and optional groups covered under the plan are included.

APPENDIX C-2: POST-ELIGIBILITY GENERAL INSTRUCTIONS

All home and community-based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made **ONLY** for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: It may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES -- §435.726 AND §435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- If the individual's spouse is not living in the individual's home, no maintenance amount is protect for that spouse's needs.
- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a

family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY -- §1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) “described in §1902(q)(1)” for the needs of the institutionalized individual. This is an allowance “which is reasonable in amount for clothing and other personal needs of the individual ... while in an institution.” For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

**POST ELIGIBILITY
REGULAR POST ELIBILITY**

1. SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based wavier services are reduced by the amount remaining after deducting the following amounts from the waiver recipient's income.
- A. 42 CFR §435.726 -- States which do not use more restrictive eligibility requirements than SSI.
- a. Allowances for the needs of the
1. Individual (check one):
- A. The following standard included under the State plan (check one):
- (1) SSI
- (2) Medically needy
- (3) The special income level for the institutionalized
- (4) The following percent of the Federal poverty level
____%
- (5) Other (specify): The maximum amount of income to be eligible under the waiver, including any income disregards or exemptions.
- B. The following dollar amount:
\$ ____*
*If this amount changes, this item will be revised.
- C. The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1 is equal to or greater than the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, enter NA in items 2 and 3 following.

2. Spouse only (check one):

- A. SSI standard
- B. Optional State supplement standard
- C. Medically needy income standard
- D. The following dollar amount:
\$____*
*If this amount changes, this item will be revised.
- E. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- F. The amount is determined using the following formula:
- G. Not applicable (N/A)

3. Family (check one):

- A. AFDC need standard
- B. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

- C. The following dollar amount:
\$____*
*If this amount changes, this item will be revised.
- D. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- E. The amount is determined using the following formula:
- F. Other

G. X Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

**POST ELIGIBILITY
REGULAR POST ELIBILITY**

1. (b) ___ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deducting the following amounts from the waiver recipient's income.

B. 42 CFR §435.735 -- States using more restrictive requirements than SSI.

a. Allowances for the needs of the

1. individual (check one):

A. ___ The following standard included under the State plan (check one):

(1) ___ SSI

(2) ___ Medically needy

(3) ___ The special income level for the institutionalized

(4) ___ The following percent of the Federal poverty level
___%

(5) ___ Other (specify):

B. ___ The following dollar amount:
\$___*

*If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1 is equal to or greater than the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, enter NA in items 2 and 3 following.

2. spouse only (check one):
- A. The following standard under 42 CFR 435.121
- B. The medically needy income standard _____
- C. The following dollar amount:
\$_____*
*If this amount changes, this item will be revised.
- D. The following percentage of the following standard that is not greater than the standards above: _____%
- E. The following formula is used to determined the amount:
- F. Not applicable (N/A)

3. Family (check one):

- A. AFDC need standard
- B. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

- C. The following dollar amount:
\$_____*
*If this amount changes, this item will be revised.
- D. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- E. The following formula is used to determined the amount:
- F. Other
- G. Not applicable (N/A)

- b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY**SPOUSAL POST ELIBILITY**

2. X The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution towards the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medically or remedial care, as specified in the State Medicaid plan.

A. Allowance for personal needs of the individual (check one):

- (a) SSI Standard
- (b) Medically Needy Standard
- (c) The special income level for the institutionalized
- (d) The following percentage of the Federal poverty level:
_____%
- (e) The following dollar amount:
\$_____*
- *If this amount changes, this item will be revised.
- (f) The following formula is used to determined the needs allowance:
- (g) Other (specify): **The maximum amount of income to be eligible under the waiver, including any income disregards or exemptions.**

If this amount is different from the amount used for individuals maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX C-3

WAIVER OF COMMUNITY INCOME AND RESOURCE POLICIES FOR THE MEDICALLY NEEDY -- §§1915(c)(3) and 1902 (a)(10)(C)(i)(III) of the Social Security Act)

- A. A waiver of §1902(a)(1)(C)(i)(III) of the Social Security Act is requested for the medically needy, in addition it item B below.
- B. The following is a description of the income and resource methods and standards that differ from those otherwise required for the medically needy under the State plan (including approved §1902(r)(2) policies) and §1902(a)(10)(C)(i)(III) for individuals living in the community.

SECOND VEHICLE EXEMPTION FOR WAIVER PROGRAM: A second vehicle may be exempt if the vehicle has been modified to accommodate the physical handicap(s) or the medical needs of the individual. Verification shall be by physician's written statement of necessity.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS**APPENDIX D-1**

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INTIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

Discharge planning team

Physician (M.D. or D.O.)

Registered Nurse, licensed in the State of California

Licensed Social Worker

Qualified Mental Retardation Professional (QMRP), as defined in 42 CFR 483.430(a)

Other (Specify):

APPENDIX D-2**a. REEVALUATIONS OF LEVEL OF CARE**

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

- Every 3 months
- Every 6 months
- Every 12 months
- Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

- The educational/professional qualifications of persons performing reevaluations of level of care are the same as those for persons performing initial evaluations.
- The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):
- Physician (M.D. or D.O.)
- Registered Nurse, licensed in the State
- Licensed Social Worker
- Qualified Mental Retardation Professional, as define in 42 CFR 483.430(a)
- Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

- "Tickler" file
- Edits in computer system
- Component part of case management
- Other (Specify): Monthly State computer-generated reevaluation reports provided to the Regional Centers.

APPENDIX D-2-a**CRITERIA FOR DENIAL OR TERMINATION OF DDS WAIVER SERVICES**

In conformance with 42 CFR Part 431, Subpart 3, a notice of action and fair hearing forms will be forwarded to the consumer by the appropriate Regional Center when DDS Waiver services are denied or reduced, or the consumer is terminated from the Waiver.

- a. Reasons for Termination of HCBS Waiver Services
 - 1. The consumer loses Medi-Cal eligibility
 - 2. The consumer elects, in writing, to terminate services
 - 3. The consumer's condition changes to the point that he/she no longer meets the eligibility criteria used to determine DDS Waiver services eligibility.
 - 4. The consumer does not meet the criteria in this Waiver, excluding Medi-Cal eligibility and level of care.
 - 5. Death of consumer
- b. Required Provision of Fair Hearing Notice
 - 1. Denial and/or reduction of services
 - 2. Termination from the Waiver for failure to meet level of care criteria.

The consumer or his/her parent or legal guardian may voluntarily disenroll from the HCBS Waiver, in which case, a notice of action and fair hearing forms will not be provided to the consumer.

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):
 - By the Medicaid agency in its central office
 - By the Medicaid agency in district/local offices
 - By the agency designated in Appendix A as having primary authority for the daily operations of the Waiver program
 - By the case managers
 - By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
 - By service providers
 - Other (Specify):
2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

The Medicaid Waiver Eligibility Record, DS 3770 form, is retained in the consumer's file at the Regional Center for a period of three years from the date of the last Waiver eligibility determination entry.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that Waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

- The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.
- The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
 - a. informed of any feasible alternatives under the Waiver; and
 - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals:
 - a. who are not given the choice of home and community-based services as an alternative to the institutional care indicated in item 2 of this request; or
 - b. who are denied the service(s) of their choice, or the provider(s) of their choice; or
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing: The Medicaid Waiver Consumer Choice of Services/Living Arrangement Statement, DS 2200 form, and the instructions for completing the form.
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the Waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services. The procedures for 3.b and 3.c are described below as a connected process completed by the Service Coordinator (case manager) with each consumer.

The Service Coordinator is responsible for informing consumers of the feasible alternatives for obtaining necessary services and giving each eligible consumer the choice of receiving necessary care and services in an institutional health facility, or a community living arrangement.

Pursuant to the DDS Policy Handbook for Federal Programs, Section 100.06, the Service Coordinator shall ensure that:

- consumers, their legal representative, parents, relatives, or involved persons are informed of the choice of either participating or not participating in the DDS Medicaid Waiver program, if the consumer is determined to be eligible for Waiver services.
 - the consumer's choice is documented on the DS 2200 form at the time of:
 - determination of initial eligibility for the Waiver program,
 - reactivation of the Waiver eligibility after a consumer's termination from participation in the Waiver program, or
 - transition from minor to adult status.
 - Waiver participants are given free choice of all qualified providers for each service included in the Individual Program Plan; and
- d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Pursuant to the DDS Policy Handbook for Federal Programs, Section 100.07, Waiver participants shall be informed of the right to an appeal or to request a fair hearing. The Service Coordinator shall ensure that a Waiver participant is notified of such a right if:

- the choice of home and community-based services versus institutional care was not offered.
- the Waiver participant was denied his/her choice of services, type of service, service provider, type of provider, or amount of service.

The current procedure for assuring that the consumer is offered the opportunity to request a fair hearing is described in the attachments to Appendix D-4.

California will fully comply with the requirements of 42 CFR Part 431, subpart E. Fair hearings will be conducted through the State Medicaid Fair Hearing process.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

The choice of home and community-based services is documented by the consumer or his/her legal representative's signature on the attached freedom of choice form (Medicaid Waiver Consumer Choice of Services/Living Arrangement Statement, DS 2200). Completed forms will be retained in the consumer's records at the appropriate Regional Center.

ATTACHMENT TO APPENDIX D-3

ASSESSMENT INSTRUMENT FOR EVALUATION & REEVALUATION

- [Client Development Evaluation Report \(CDER\) Diagnostic Element](#)
- [CDER Manual](#)

ATTACHMENT #1 TO APPENDIX D-4

FREEDOM OF CHOICE DOCUMENTATION

- Medicaid Waiver Consumer Choice of Services/Living Arrangement Statement Form (DS 2200)

**MEDICAID WAIVER CONSUMER CHOICE
OF SERVICES/LIVING ARRANGEMENT STATEMENT**

DS 2200 (Rev. 2/2000) (Electronic Version)

The consumer, parent/legal guardian, or legal representative, or involved other person has been informed of the feasible alternative of services available. The consumer has been offered a choice of receiving such services in a community care residential facility, in an in-home living arrangement, or in a long-term health facility (ICF/DD, ICF/DD-H, or ICF/DD-N).

Consumer Identification Information/Date of Choice

Consumer's Name	Date of Choice (date form completed)
UCI	DOB

Choice of Services/Living Arrangement

I. MINORS

The consumer is a minor. The choice of living arrangement has been made by the parent, legal guardian, or legal representative as indicated in Section III below:

_____ Date
 Signature

II. ADULTS

a. The consumer is an adult and has chosen the living arrangement as indicated in Section III below:

_____ Date _____ Date
 Client's signature/mark ("X") Witness' signature

The consumer is an adult but is unable to make such choice. The choice of living arrangement has been made by:

- b. The consumer's legal representative; or, if the client has no legal representative
- c. The consumer's parents, relatives or other persons actively involved in the development of the consumer's plan of care;

_____ Date
 Signature

III. SERVICES/LIVING ARRANGEMENT

- A. A long-term health facility (ICF/DD, ICF/DD-H, or ICF/DD-N)
- B. A community care residential facility, or
- C. Consumer's choice of living arrangement other than above (please specify): _____

IV. DISENROLLMENT FROM MEDICAID WAIVER

- A. I choose/my legal guardian/representative chooses to terminate my Medicaid Waiver participation. Since this is my choice, I will not be requesting a fair hearing.

_____ Date
 Signature

V. COMMENTS:

INSTRUCTIONS FOR MEDICAID WAIVER CONSUMER CHOICE OF SERVICES/LIVING ARRANGEMENT STATEMENT

Under the terms of the Title XIX Medicaid Waiver Program, each consumer must be informed of any feasible alternative services under the Waiver and be given a choice of receiving those services in a community care residential facility, in-home living arrangement, or long-term health facility. If those services are not offered or available, the consumer or his or her representative must be apprised of his/her right to a fair hearing.

The DS 2200 Medicaid Waiver Consumer Choice of Services/Living Arrangement is to be completed as follows:

Consumer Identification Information/Date of Choice

Enter the consumer's first and last name.

Enter the date the choice is offered which should be concurrent with the date the consumer is either initially enrolled in the Medicaid Waiver program or the date of reenrollment in the Medicaid Waiver program after a period of ineligibility greater than 120 days.

Enter the consumer's unique identifier (UCI).

Enter the consumer's date of birth.

Choice of Services/Living Arrangement

The following persons are responsible for making the Medicaid Waiver choice of services/living arrangement determination. The signature of such persons must be consistent with the signatures for other consent forms, release of information forms, etc. contained in the consumer's record.

Minors

The parent/legal guardian/legal representative must make the choice by marking the box indicating who is making the choice, signing, and dating the form. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

Adults

- a. The consumer indicates his/her choice by signing his/her name or making his/her mark. The consumer's mark must be witnessed. A representative of the interdisciplinary (ID) team may be a witness. The choice form must be dated. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

OR

- b. The consumer has a legal representative. The legal representative must make the choice by marking the box indicating who is making the choice, signing and dating the form. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

OR

The ID Team

- c. Parents, relatives, or others involved in the development of the consumer's plan of care who represent the ID team for those consumers who are not able to indicate their choice and do not have a legal representative must make the choice by marking the box indicating who is making the choice, signing, and the dating the form. Box A, B, or C in Section III, Services/Living Arrangement must be marked.

Consumer Choice to Disenroll from the HCBS Waiver Program

Should an HCBS consumer or his/her parent, legal guardian, representative wish to voluntarily terminate enrollment, the consumer or his/her parent, legal guardian, representative should mark the box and sign and date the form to document his/her/their choice.

Comments

Use this section to provide any clarification or explanation with either the choice of services/living arrangement, the signatures, or dates provided.

NOTE: In those instances when services or choice of living arrangement (community or health facility) cannot be provided, the consumer/parent/legal guardian or legal representative/other involved person must be apprised that they are entitled to a fair hearing.

ATTACHMENT #2 TO APPENDIX D-4

FAIR HEARING PROCESS AND FORMS

- [Brochure on “The Fair Hearing Process for Consumers Age 3 Years and Older”](#)
- [Notice of Proposed Action form, DS 1803 \(Rev. 11/99\)](#)
- [Notification of Resolution form, DS 1804 \(Rev. 6/01\)](#)
- [Fair Hearing Request form, DS 1805 \(Rev. 1/01\)](#)

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

Registered nurse, licensed to practice in the State.

Licensed practical or vocational nurse, acting within the scope of practice under State law.

Physician (M.D. or D.O.) licensed to practice in the State of California

Social Worker (qualifications attached to this Appendix)

Case Manager

Other (Specify): The individual program plan (plan of care) is developed through a process of individualized needs determination, **which includes gathering information from providers of services and supports,** and is prepared jointly by the planning team. The planning team, at a minimum, consists of the individual with developmental disabilities and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, and an authorized Regional Center representative. **With the consent of the consumer/conservator, other individuals, including service providers, may receive notice of the meeting and participate.**

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

At the Medicaid agency central office

At the Medicaid agency county/regional offices

By case managers

By the agency specified in Appendix A

By consumers

Other (Specify): **At the Regional Center**

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this Waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

Every 3 months

Every 6 months

Every 12 months

Other (Specify): Although reviews will be conducted every 12 months, regional center QMRP's, clinical teams, and/or DHS health care professionals may determine if more frequent reviews are necessary, particularly for individuals whose medication regimes require special follow-up. Each Individual Program Plan (IPP) will be reviewed annually.

- a. The IPPs of Waiver consumers are reviewed annually by the planning team at all Regional Centers.
- b. The majority of Regional Centers now complete a new IPP document subsequent to the annual review meeting. Therefore completion of the DDS "Standardized Annual Review Form" is no longer needed to document the results of the annual review which are contained in the new IPP document.
- c. Some Regional Centers complete a new IPP document triennially and amend the existing IPP if changes are needed to meet the consumer's needs. These centers will continue to use the DDS "Standardized Annual Review" form to document the annual review of the consumer's IPP. If new services or supports are needed, the IPP will be amended to include the new services or supports. The planning team members will sign the "Standardized Annual Review" form to document that the remainder of the IPP remains appropriate to meet the consumer's needs. If no new services or supports are required, the planning team will indicate that the IPP remains appropriate to meet the consumer's needs.

APPENDIX E-2**a. MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The DHS Monitoring Team will participate in bi-annual Regional Center monitoring reviews coordinated with DDS. The plan of care will be evaluated for:

1. Appropriate representation during development of the plan of care.
2. Documentation of review and update, if necessary, every 12 months.
3. Compliance with statutory requirements for service type, amount, frequency, duration, and provider type.
4. Verification that services are consistent with assessed needs.

Written reports of findings will be documented with required plan of correction.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this Waiver is attached to this Appendix.

The California requirements for the IPP/Individual Family Service Plan meet the Federal requirements for the plan of care.

ATTACHMENT TO APPENDIX E-2

PLAN OF CARE FORM

- Lanterman Individual Program Plan (IPP) Requirements
- Sample IPP – Eastern Los Angeles Regional Center
- [Standardized Annual Review Form](#)

LANTERMAN IPP MANDATES AND DOCUMENTATION REQUIREMENTS

1. IPPs are prepared jointly by the planning team.
2. Decisions concerning the consumer's goals, objectives, and services and supports that will be included in the IPP and purchased by the regional center or obtained from generic agencies shall be made by agreement by the regional center representative and the consumer or, where appropriate, the parents, legal guardian, conservator, or authorized representative at the program planning meeting.
3. An authorized representative of the regional center and the consumer or, where appropriate, the parents, legal guardian, or conservator, shall sign the individual program prior to its implementation.
4. The IPP shall include a statement of goals based on the needs, preferences, and life choices of the individual.
5. The IPP shall include a statement of specific, time-limited objectives for implementing the person's goals and addressing his or her needs.
6. The IPP objectives shall be stated in terms that allow measurement of progress for monitoring of services delivery.
7. The IPP shall include a schedule of the type and amount of service and supports to be purchased by the regional center or obtained from generic agencies or other resources in order to achieve the IPP goals and objectives.
8. The schedule of the services and supports in the IPP shall include the identification of the provider or providers of service responsible for attaining each objective, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports.
9. The IPP shall specify the approximate scheduled start date for services and supports and shall contain timelines for actions necessary to begin service and supports, including generic services.
10. The IPP shall specify a schedule of regular periodic review and reevaluations to ascertain that planned services have been provided, that objectives have been fulfilled within the times specified, and that consumers and families are satisfied with the IPP and its implementation.
11. The IPP shall, be reviewed and modified by the planning team, as necessary, [for HCB waiver cases, at least annually].

Eastern Los Angeles Regional Center

IPP SIGNATURE PAGE

CONFIDENTIAL CONSUMER INFORMATION
See California Welfare & Institutions Code, Section 4514

NAME: [REDACTED] DATE OF BIRTH: 3-11-67
UCI#: [REDACTED] IPP CONFERENCE DATE: 3-28-02

SERVICE COORDINATOR/PEER CONSULTANT REVIEW

- All parties agree/disagree that Carol T. continue as Service Coordinator (SC)/Peer Consultant
(Please circle preference)
- I have informed the consumer or his/her authorized representative that non confidential service and performance records of most ELARC vendors are available for review
- W/D Adult consumers expressed their verbal or written preference for family involvement at the IPP
(Please circle verbal or written consumer preference above)
- Support Living Services and other Community Living Options were discussed with Consumer and/or Legal Representative
- Complaint Procedure has been explained per (WIC, Section 4731)
- HCBS Waiver Case

(Check all appropriate Boxes)

Review of my goals to be completed Monthly Quarterly Semi-annually Annually

Type of Plan Initial 30-Day Annual Biennial Triennial Addendum

* REMINDER: IPP MUST BE REVIEWED ANNUALLY

Annual Review Resulted in No changes to IPP Please see attached addendum for changes

IPP Dated () still in effect

We, the undersigned, met today and agreed to the outcomes and plans described in this IPP

<input checked="" type="checkbox"/>	_____ Parent/Legal Guardian/Conservator	_____ Date
<input checked="" type="checkbox"/>	<u>[REDACTED]</u> Consumer	<u>3/28/02</u> Date
<input checked="" type="checkbox"/>	<u>[Signature]</u> Service Coordinator/ Peer consultant	<u>3-28-02</u> Date
<input checked="" type="checkbox"/>	<u>[Signature]</u> Signature/Title <u>E.S. Program Director</u>	<u>3/28/02</u> Date
<input checked="" type="checkbox"/>	<u>[Signature]</u> Signature/Title <u>Carol S. Wollongren</u>	<u>3/28/02</u> Date
<input checked="" type="checkbox"/>	<u>[Signature]</u> Regional Center Supervisor	<u>5/2/02</u> Date

Eastern Los Angeles Regional Center

IPP SIGNATURE PAGE

PAGE 2

CONFIDENTIAL CONSUMER INFORMATION

See California Welfare & Institutions Code, Section 4514

Name:

[REDACTED]

Date of Birth:

3-11-67

UCI #:

[REDACTED]

IPP Conference Date:

3-28-02

I. I understand that if an agreement, in part or in whole, cannot be reached at the first planning meeting, a second meeting must be held within 15 days, or later, with the consent of the consumer or his/her representative.

_____ (Initial/Date)

II. I disagree with the following objectives/plans (enter only the corresponding number below):

_____ (Initial/Date)

* Date of meeting to resolve issue (must be held within 15 days unless consumer/representative initials waiver below): _____

I waive my right to a second planning meeting within 15 days and agree to contact my service coordinator to schedule the meeting.

_____ (Initial/Date)

III. My initials on this line indicate that the team will not need to reconvene a meeting solely to determine any mutually agreed upon addendums to the IPP developed today. Other means, such as a telephone call or office visit, may suffice.

[REDACTED] 3/28/02
_____ (Initial/Date)

Service Provision Agreement based on Person Centered Planning Meeting (I.P.P)

Name: [REDACTED]
 UCI: [REDACTED]
 Date: 3-28-02

Service (vendedored/generic)	Service Provider	Frequency of Service	Start Date	Duration of Service	Responsible Agency/Group Including Payment Arrangements
COMMUNITY CARE FACILITY - LEVEL II <u>Day Program</u>	PTL BEST WONG PAR EASTING SERVICES	24 HRS/DAY 7 DAYS/WK	3/28/02	UNTIL APPROPRIATE PLACEMENT IS FOUND	SSI / ELAC
<u>Heart Care</u>		5 DAYS/WK 9 HRS/DAY	-	2-7-02	DEPT. OF REHAB.
PRIMARY PHYSICIAN DENTIST	DR. DALIO DR. YOON	NO NEEDED ONCE A YEAR	- -	AS NEEDED -	MEDI-CAL ↓

Eastern Los Angeles Regional Center

[x]
1000 S. Fremont Ave.
Alhambra, Calif. 91802-7916
(626) 299-4700

[]
13215 Penn St. #410
Whittier, Calif. 90602
(562) 698-0146

INDIVIDUAL PROGRAM PLAN

CONFIDENTIAL CONSUMER INFORMATION

See California Welfare &
Institutions Code, Section 4514

WHO IS THIS ABOUT?

NAME: [REDACTED]

DATE OF BIRTH: 3/11/67

UCI #: [REDACTED]

IPP CONFERENCE DATE: 3/28/02

NOTIFICATION OF IPP CONFERENCE AND REQUEST FOR INPUT:

The following were notified by telephone:

Carol Wollenzier: Administrator

Margaret Rios: Par Eastside Counselor

The following people helped with the program:

[REDACTED] Consumer

Carol Wollenzier.: Administrator

Margaret Rios: Par Eastside Counselor (IHC on 3/19/02)

Sylvia Fierro-Schneider: Easter Seals Program Director

Cesar Torres: Service Coordinator

The following were invited by letter:

[REDACTED] Consumer

Margaret Rios: Par Eastside Counselor

Easter Seals

No family involvement.

Consumer preference was sought for the location of this meeting: The IPP meeting was conducted at PTL Guest Home where [REDACTED] felt more comfortable.

Hope & Dreams about the future:

1. [REDACTED] would like to live with a room mate in an apartment.
2. [REDACTED] wants to continue to be healthy.
3. [REDACTED] wants to continue to work at Par Eastside Workshop.
4. [REDACTED] wants to do more involve in more social activities.

Some Great Things about me:

1. [REDACTED] likes working and earning money.
2. [REDACTED] likes to help in the house such as cooking and cleaning.
3. [REDACTED] likes to attend dances at Palm Park and likes to travel to places.
4. [REDACTED] is friendly and can express her wants and needs.

PERSON CENTERED OBJECTIVES

HOW I WILL REACH MY GOALS IN LIFE

The following IPP was created by the interdisciplinary team to address [REDACTED] wants and needs. She has participated in the development of these IPP objectives.

1) Current Situation:

One of [REDACTED]'s goals is to move with a room mate into an apartment under supported living services. [REDACTED] has agreed to receive services from Easter Seals Program in Alhambra. [REDACTED] did received

three months of supported services with Easter Seals during her transitional period which required apartment search, etc. Unfortunately, [REDACTED] was not happy with the apartments she saw during her transitional. [REDACTED] has requested to continue with services because she wants to move out as soon as possible. Easter Seal Program Director has requested 20-25 hours per month of ILS services in order to meet [REDACTED] goal as soon as possible. [REDACTED] has been informed that she needs to continue to work with her independent living skills and money management skills. [REDACTED] has also been saving money in order to buy furniture, etc. Some of her other goals are staying healthy, and keep attending her program. [REDACTED] will continue to live at PTL Guest Home until an apartment has been found for her. PTL Guest home will continue to provide 24 hour care and supervision for [REDACTED].

Desired/Outcome:

[REDACTED] would like to move with a room mate into an apartment. Easter Seals is under this service and will continue to do so until placement is found for her. At the meantime, PTL Guest Home will continue to provide 24 hour care and supervision for [REDACTED].

Services and Supports Needed:

1. My part will be:

- A. [REDACTED] will continue to follow the house rules and cooperate with her care providers.
- B. [REDACTED] will continue to interact appropriately with PTL Guest staff and her house mates.

(Date this will happen: 3/02-3/03)

2. From family, friends and community:

- A. No family involvement.
- B. Margaret Rios of Par Eastside will continue to communicate with [REDACTED] and address any concerns regarding her health and care.
- C. Margaret Rios will continue to communicate and try her best to meet with regional center service coordinator and participate in [REDACTED] IPP development.

(Date this will happen: 3/02-3/03)

3. From support service agencies:

- A. Social Security and ELARC funds will continue to be utilized to fund board and care needs.
- B. ELARC will continue to provide supplemental funding at Level II rate as long as this placement continues to be the least restrictive environment and continues to provide a good quality of life for [REDACTED].
- C. PTL Guest Home will continue to maintain financial records and receipts in a chronological ledger reflecting [REDACTED] P&I utilization and balance.
- D. PTL Guest Home will continue to implement [REDACTED] current IPP/Facility Plan and meet with Regional Center Service Coordinator at least quarterly for progress review.
- E. PTL Guest Home will continue to maintain monthly notes and data reports regarding [REDACTED] IPP implementation.
- F. PTL Guest Home will continue to provide transportation to appointments and recreational and/or social activities for [REDACTED].
- G. A meeting will be held to determine the hours needed for ILS services for [REDACTED].

(Date this will happen: 3/02-3/03)

II)

Current Situation:

██████████ attends Par Eastside Workshop five days per week from 8:00 A.M. to 2:30 P.M. This is a site-based workshop in Santa Fe Springs. ██████████'s individual habilitation component plan was held on 3/19/02 at Par Eastside. Some of ██████████'s IHC plan addresses her needs in how to demonstrate job task and ways to communicate with staff and workers. Some of the duties that she continues to do are putting labels on boxes and working on all steps of machinery assigned to her; it is reported by staff that she has been doing excellent - no behavior problems to report. Some of her goals that she has not met are in the following: she needs to improve in counting her items that have been completed; and place jobs that require counting. Some of the new goals she will be working on are in the following: she will be train to put plastic film in the sealer machine; and to learn how to count items. Staff has been happy with ██████████ because she communicates with other people; however, she continues to get involved in other people's affairs. ██████████ has been reminded not to gossip to co-workers during working hours. Overall, ██████████ is a good worker who completes her job assignments and has completed all steps of her working position. Again, she gets along with staff, likes her job and everything about the workshop. ██████████ has reported that she does not want to go into supported employment nor work out in the community. ██████████ has overall done well in her day program and seems to enjoy it. Also, the ID Team has recommended for ██████████ to be given mobility training. A referral packet will be distributed to several mobility training agencies.

Desired/Outcome:

██████████ would like to continue to work at Par Eastside and do her best to meet her goals at the workshop. Par Eastside will continue to provide day program services for ██████████

1. My part will be:

- A. ██████████ will continue to follow the workshop rules.
- B. ██████████ will continue to participate in the workshop's activities to the best of her abilities.

(Date this will happen: 3/02-3/03)

2. From family, friends and community:

- A. Margaret Rios and PTL Guest staff will continue to encourage ██████████'s efforts.
- B. Margaret Rios will continue to keep in contact with Rhonda's care provider regarding ██████████'s needs and desires.

(Date this will happen: 3/02-3/03)

3. From support service agencies:

- A. Dept. of Rehabilitation will fund this program and ELARC will continue to fund transportation.
- B. Par Eastside program will continue to develop and implement ██████████'s Individual Service Plan.
- C. Par Eastside program will continue to inform ELARC Service Coordinator of all meetings regarding Rhonda's plans and needs.

(Date this will happen: 3/02-3/03)

Eastern Los Angeles Regional Center

Medicaid Waiver Service Plans

Consumer: [REDACTED]

DOB: 3/11/67

Face to Face Meeting Date: 3/28/02

UCI#: [REDACTED]

The following service needs are addressed in accordance with Medicaid Waiver regulations. These services have been assessed and selected by the Interdisciplinary Team. These services are intended to expand the consumer's ability to select among other community-based options of work, living and recreation. Effort has been made to offer the services in as normal and in as unrestrictive manner as possible. These Medicaid Waiver services promote the personal goals selected by [REDACTED] without jeopardizing his/her health and safety in the community. The participants of this planning conference have agreed to provide these services in accordance with the established Title 17 and Title 22 regulations and the principles of self-determination stipulated by the Lanterman Act.

Identified Medicaid Waiver Services

1. LIVING ARRANGEMENT OPTION

Current Situation:

[REDACTED] currently lives at PTL Guest Home, a level II community care facility for adults located in a quiet, nice neighborhood in the city of Whittier. PTL Guest Home address and telephone number are [REDACTED]. [REDACTED] receives care and supervision here in this home. One of [REDACTED]'s goals is to move into her own place under supported living services. [REDACTED] has agreed to One of [REDACTED]'s goals is to move with a room mate into an apartment under supported living services. [REDACTED] has agreed to receive services from Easter Seals Program in Alhambra. [REDACTED] did received three months of supported services with Easter Seals during her transitional period which required apartment search, etc. Unfortunately, [REDACTED] was not happy with the apartments she saw during her transitional. [REDACTED] has requested to continue with services because she wants to move out as soon as possible. Easter Seal Program Director has requested 20-25 hours per month of ILS services in order to meet [REDACTED] goal as soon as possible. [REDACTED] has been informed that she needs to continue to work with her independent living skills and money management skills. [REDACTED] has also been saving money in order to buy furniture, etc. Some of her other goals are staying healthy, and keep attending her program. [REDACTED] will continue to live at PTL Guest Home until an apartment has been found for her. PTL Guest home will continue to provide 24 hour care and supervision for [REDACTED].

Objective/Outcome:

[REDACTED] would like to move out with a room mate into an apartment near her work. Easter Seals will continue to evaluate [REDACTED] under this service and will continue to do so until placement is found for her. At the meantime, PTL Guest Home will continue to provide 24 hour care and supervision for [REDACTED].

Target Date: 3/02-3/03

Plans of Intervention:

- A. [REDACTED] will continue to express her choices and preferences.
- B. Margaret Rios, counselor of Par Eastside, will continue to communicate with [REDACTED] and address any concerns regarding home staff and care to Service Coordinator.
- C. Margaret Rios will continue to communicate and meet with regional center service coordinator

- and participate in Rhonda's IPP development.
- D. PTL Guest Home will continue to maintain financial records and receipts in a chronological ledger reflecting [REDACTED]'s P&I utilization and balance.
 - E. PTL Guest Home will continue to implement the current IPP/Facility Plan and meet with Regional Center Service Coordinator at least quarterly for progress review.
 - F. PTL Guest Home will continue to maintain monthly notes and data reports regarding [REDACTED] IPP implementation.
 - G. PTL Guest Home will continue to provide transportation to appointments and recreational and/or social activities for [REDACTED].
 - H. Easter Seals will continue to evaluate [REDACTED] and a meeting will be held to determine the hours needed for ILS services for [REDACTED].

Funding Source:

- A. Social Security and ELARC funds will continue to be utilized to fund board and care needs.
- B. ELARC will continue to provide supplemental funding at Level II rate.
- C. ELARC will fund Easter Seals ILS services if approved by supervisor.

2. VOCATIONAL/EDUCATIONAL/DAY PROGRAM

Current Situation:

[REDACTED] attends Par Eastside Workshop five days per week from 8:00 A.M. to 2:30 P.M. This is a site-based workshop in Santa Fe Springs. The address and telephone of Par Eastside are 8708 Sorensen Ave, Santa Fe Springs, CA. 90670; (562) 945-4283. Some of [REDACTED]'s IHC plan addresses her needs in how to demonstrate job task and ways to communicate with staff and workers. Some of the duties that she continues to do are putting labels on boxes and working on all steps of machinery assigned to her; it is reported by staff that she has been doing excellent - no behavior problems to report. Some of her goals that she has not met are in the following: she needs to improve in counting her items that have been completed; and place jobs that require counting. Some of the new goals she will be working on are in the following: she will be train to put plastic film in the sealer machine; and to learn how to count items. Staff has been happy with [REDACTED] because she communicates with other people; however, she continues to get involved in other people's affairs. [REDACTED] has been reminded not to gossip to co-workers during working hours. Overall, [REDACTED] is a good worker who completes her job assignments and has completed all steps of her working position. Again, she gets along with staff, likes her job and everything about the workshop. [REDACTED] has reported that she does not want to go into supported employment nor work out in the community. [REDACTED] has overall done well in her day program and seems to enjoy it. Also, the ID Team has recommended for [REDACTED] to be given mobility training. A referral packet will be distributed to several mobility training agencies.

Objective/Outcome:

[REDACTED] would like to continue to work at Par Eastside and do her best to meet her goals at the workshop. Par Eastside will continue to provide day program services for [REDACTED]. The ID Team has recommended for [REDACTED] to receive mobility training.

Target Date: 3/02-3/03

Plans of Intervention:

- A. Par Eastside Individual Habilitation Component plan (IHC) will address [REDACTED]'s objectives and needs.
- B. Par Eastside IHC will include job task plans to increase [REDACTED]'s independent working skills.
- C. Par Eastside will inform ELARC Service Coordinator of all meetings regarding [REDACTED]'s individual plan.
- D. ELARC will distribute a referral packet to several mobility training agencies.

Funding Source:

- A. Dept. of Rehabilitation will continue to fund Par Eastside Workshop.
- B. ELARC will continue to fund transportation to and from Par Eastside.

3. HEALTH/MEDICAL/DENTAL

Current Situation:

[REDACTED] has a diagnosis of Mild Mental Retardation, Schizophrenia, Chronic Residual Typ, and hypertension. It is reported that she continues to take iron supplements for Anemia. She also continues to take Triamterene for blood pressure. [REDACTED] weighs 145 lbs. and she is 5'4" feet tall. [REDACTED]'s new primary care physician is Dr. Marian Jalil. [REDACTED] had a physical examination on 3/28/02 with Dr. Jalil. Her last lab results was reported on 10/8/01; results were within the normal range. [REDACTED]'s last dental examination was 3/9/02 with Dr. Yoon; she had x-rays and cleaning. She is scheduled to return back to the dentist on 3/30/02 for deep cleaning. [REDACTED] had a routine pap smear done on 2/6/01 with gynecologist Dr. Bhupathy for vaginal discharge. She was also seen on 9/4/01 and 10/4/01 for recurrent vaginitis; treatment was given. [REDACTED] saw the Dr. Bartis, podiatrist, on 1/28/02 for long thick toenails; treatment and cleaning were given. [REDACTED] has prescribed glasses but refuses to wear them. [REDACTED] vision and hearing are within the normal limits. It has been cleared up that [REDACTED] does not wear a hearing aid. [REDACTED]'s health professionals are as follows:

(New Doctor) Dr. Marian Jalil, primary physician - (562) 945-7671
 14350 E. Whittier Blvd., Ste. 200
 Whittier, CA. 90605

Dr. Kyuong O. Yoon, Dentist - Whittier Family Dental Office
 11727 Whittier Blvd., Whittier, CA. 90601

Dr. Manuel Gonzales, Optometrist - (562) 868-2418
 11552 E. Telegraph, Santa Fe Springs, CA 90670

Dr. Vellore Bhupathy, Gynecologist - (562) 945-3707
 15141 E. Whittier Blvd., CA 90603

Whittier Hearing Aid Center - (562) 698-0581
 13121 E. Philadelphia St., CA 90601

The following are [REDACTED] current medication and supplements:

MEDICATION/SUPPLEMENTS	DOSAGE	FREQUENCY	REASON
Triamterene	50/HCTZ	One cap every other day	For blood pressure
Folic Acid	1MG	One tab in the morning	For Anemia
Ferrous Sulfate	325MG	One tab twice a day w/ food	Iron supplement (anemia)

The above medication have the following side effects: Dizziness or blurred vision for Triamterene; stomach cramps, constipation, heartburn, nausea for Ferrous Sulfate.

Objective/Outcome:

[REDACTED] would like to continue to receive health services and be in stable health. PTL Guest staff will continue to provide and assist [REDACTED] in this area.

Target Date: 3/02-3/03

Plans of Intervention:

- A. PTL Guest Home will continue to schedule medical and dental appointments and any other needed medical procedures.
- B. PTL Guest Home will continue to obtain written reports from [REDACTED]'s physicians and forward copies to ELARC in a timely manner.
- C. PTL Guest Home will continue to provide transportation for [REDACTED] to and from all medical appointments.
- E. PTL Guest Home will continue to follow physicians' orders regarding [REDACTED]'s care and treatment.

Funding Source:

- A. Medi-Cal and will continue to fund [REDACTED]'s medical and health care.
- B. Regional Center will fund necessary medical services denied from Medi-Cal..

4. PSYCHIATRIST

Current Situation:

[REDACTED] has not seen her psychiatrist Dr. Chung since 3/29/99 because she has not been exhibiting behaviors and Dr. Chung recommended that it is not needed for her to continue psychiatric services at this time; also psychotropic medication has been discontinued since early of 1999. Although [REDACTED] is diagnosed with Schizophrenia, Chronic Residual Type, she has been in good behavior. [REDACTED] does have a history of intrusive behaviors- such as losing her focus on her activities and commanding (bossiness) her peers to do various chores at home or at the day program. It has been reported by the administrator that [REDACTED] continues to get involve in other people's affairs and can be very bossy on a daily basis. Other than these minor behaviors, she has been doing well and does not exhibit any self-injurious behaviors, property destruction, nor physical aggression. [REDACTED]'s psychiatrist name and address is as follows:

Dr. Chung, Psychiatrist - (562) 801-4626
 ALMA Services
 9140 Whittier Blvd., Pico Rivera, CA 90660

Objective/Outcome:

[REDACTED] will continue to be in good behavior and in stable health. In case [REDACTED] does exhibit maladaptive behaviors, PTL Guest Home will assist and redirect her of any maladaptive behaviors.

Target Date: 3/02-3/03

Plans of Intervention:

- A. PTL Guest Home will schedule psychiatric appointments and any other needed psychiatric procedures if needed.
- B. PTL Guest Home will continue to obtain written reports from [REDACTED]'s psychiatrist and forward copies to ELARC in a timely manner when psychiatric services have been given to [REDACTED]
- C. PTL Guest Home will continue to provide transportation for [REDACTED] to and from all psychiatric appointments when needed.
- D. PTL Guest Home will continue to follow psychiatrist orders regarding [REDACTED]'s care and treatment when given by the psychiatrist.

Funding Source:

- A. Medi-Cal will continue to fund [REDACTED]'s psychiatric care when needed.
- B. Regional Center will fund necessary psychiatric services denied by Medi-Cal.

5. SOCIAL ACTIVITIES

Current Situation:

[REDACTED] enjoys participating in outings with Carol and her room mates to the community and going to local trips. [REDACTED] also enjoys watching television, and likes going out dancing on Friday's to Palm park. [REDACTED]'s favorite activity is cooking; she continues to help Carol in the kitchen. [REDACTED] likes to cook meals such as spaghetti, chicken, macaroni cheese, meatloaf, and pork chops. [REDACTED] hasn't had any family contact since November 2001. [REDACTED]'s sister called her to let her know that their grandmother past away. Her sister was also supposed to visit her in Christmas but never came or called. [REDACTED] does have 3 biological. It was reported that the relatives of the father have received full custody and children have been adopted, according to staff member. [REDACTED] has stated that she feels okay about not seeing her children; as long as they are happy and being taken care of by their adopted parents. [REDACTED] has requested to attend a camping trip this year with Camping Around. Administrator Carol has been advised to contact Camping Around in order to obtain registration forms.

Objective/Outcome:

[REDACTED] will participate more fully in community recreational activities. PTL Guest home will continue take [REDACTED] out to the community. Rhonda has requested to attend a camping trip with Camping Around this summer.

Target Date: 3/02-3/03

Plans of Intervention:

- A. PTL Guest Home will continue to assist [REDACTED] in participating in social/recreational and community activities.
- B. PTL Guest will continue to encourage and reinforce [REDACTED] participation in social/recreational activities.
- C. PTL Guest Home will assist [REDACTED] in finding her classes for math and reading and as well as making contact with her children per [REDACTED] needs and choices.
- D. PTL Guest Home will observe [REDACTED] reactions when participating in social recreational activities and provide more opportunities for her participation in those activities that she enjoys.
- E. PTL Guest Home will continue to make contact with [REDACTED] family and do the best to have the family get involve with [REDACTED]
- F. PTL Guest Home will contact Camping Around in order to obtain registration forms.

Funding Source:

- A. PTL Guest Home will incur the cost of all facility outings. ELARC will fund for camping trip according to POS guidelines.

6. SELF- HELP

Current Situation:

[REDACTED] is able to do most of her personal hygiene and dressing tasks; however, she continues to require verbal prompts on taking a bath, washing her hair thoroughly, brushing her teeth, and to maintain a clean room.. She does bathe or shower by herself. She has bladder control during the day and night. She is able to feed herself using fork and spoon with no spillage. [REDACTED] however cooperates and follows directions to the best of her ability. PTL Guest Home will developed plans to assist [REDACTED] in gaining more independence in self-help tasks. [REDACTED] handles her own money and will buy her own things with minimal supervision. [REDACTED] is able to handle some responsibilities at her home. For example, she can feed her dog, vacuum the rooms, wash dishes, pick-up dog mess on the floors, and change her own bed sheets. She can also cook meals- she usually can cook meals such

as spaghetti, chicken, macaroni cheese, meatloaf, and pork chops. [REDACTED] is also able to do her own laundry and does this chore on a weekly basis.

Objective/Outcome:

[REDACTED] will become as independent as possible in self-help activities.

Eating: [REDACTED] is independent and requires no assistance in this area.
 Toileting: [REDACTED] is independent and requires no assistance in this area.
 Bladder/Bowel: [REDACTED] is independent and requires no assistance in this area.
 Hygiene: [REDACTED] requires verbal prompts with bathing, washing her hair thoroughly, brushing teeth, and to maintain a clean room..
 Bathing: [REDACTED] will not bathe if not reminded; requires verbal prompts in bathing or showering.
 Dressing: [REDACTED] is able to dress independently.

Target Date: 3/02-3/03

Plans of Intervention:

- A. PTL Guest Home staff will continue to verbally prompt [REDACTED] in needed self-help areas.
- B. PTL Guest Home staff will continue to assist [REDACTED] in her daily hygiene activities while at the same time encouraging her independence.
- C. PTL Guest Home staff will continue to provide age appropriate and seasonably comfortable dressing for [REDACTED] taking into consideration her likes and dislikes.
- B. PTL Guest Home staff will continue to praise [REDACTED] for her efforts in reaching her personal care goals.

Funding Source:

Social Security and ELARC will fund PTL Guest Home.

7. BEHAVIOR

Current Situation:

[REDACTED] does have a history of intrusive behaviors- such as losing her focus on her activities and commanding (bossiness) her peers to do various chores at home or at the day program. It has been reported by the administrator that [REDACTED] continues to get involve in other people's affairs and can be very bossy on a daily basis. Other than these minor behaviors, she has been doing well and does not exhibit any self-injurious behaviors, property destruction, nor physical aggression.

Objective/Outcome:

[REDACTED] will do her best to get along with her staff and peers without causing disagreements for the safety of her behavior. She will also do her best not to get involve in other people's affairs.

Target Date: 3/02-3/03

Plans of Intervention:

- A. PTL Guest Home have formally observed [REDACTED] and noted the antecedents to [REDACTED] tantrums. PTL Guest Home will include written plans to address [REDACTED]'s noncompliance.
- A. PTL Guest Home staff will provide close supervision for [REDACTED] and redirect her when she begins to exhibit inappropriate behaviors.

Funding Source:

A. Social Security and ELARC will fund PTL Guest Home.

CC: Consumer's File
PTL Guest Home
PAR Eastside Services
Easter Seals Supported Services

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by section 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of the Waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the Waiver.
3. Method of payments (check one):

Payments for all Waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, Waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

Payment for Waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

Services are provided by vendors subcontracted to private non-profit corporations called Regional Centers which operate under contract with the Department of Developmental Services (DDS). The Regional Centers reimburse the providers for the authorized services under a fiscal agent contract with DDS. The Regional Centers then bill DDS, which operates the Waiver program under an interagency agreement and fiscal agent contract with the Department of Health Services, the Medicaid agency. DDS has developed an approved MMIS.

Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of Waiver services are made only:
 - a. When the individual was eligible for Medicaid Waiver payment on the date of service;
 - b. When the service was included in the approved plan of care;
 - c. In the case of supported employment, prevocational, or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individual's with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

Yes
 No
2. The following is a description of all records maintained in connection with an audit trail. Check one:

All claims are processed through an approved MMIS.
 MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.
3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of Waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

The Medicaid agency will make payments directly to providers of Waiver services.

The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

The Medicaid agency will pay providers through the use of a limited fiscal agency who functions only to pay Waiver claims.

Providers may voluntarily reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

ATTACHMENT TO APPENDIX F
BILLING PROCESS AND RECORDS RETENTION

BILLING PROCESS AND RECORDS RETENTION

The State of California assures CMS that the agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its Waiver program (except as CMS may otherwise specify for particular Waivers), and it will maintain and make available to the HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the Waiver, including reports of any independent audits conducted.

The Medicaid eligibility of consumers for whom bills for services have been received is verified through an automated check through the Medicaid Eligibility Data System (MEDS) operated by the Medicaid agency, the Department of Health Services.

- Department of Developmental Services (DDS)

Financial accountability is assured through the use of the Uniform Fiscal System (UFS), a comprehensive uniform accounting, encumbrance, budgeting, reporting, and billing system. The system establishes and tracks Regional Center authorization and billing data by vendor number, authorization number, consumer number, service code, and general ledger account number. Waiver services will not be paid unless the appropriate authorization and billing data have been provided.

The Regional Centers transmit to DDS all service authorization and billing data necessary to support the provider claims to provide a complete audit trail.

Records maintained at DDS in the UFS include:

1. Billing Regional Center.
2. Unique Client Identifier (UCI)
3. Social Security Number
4. Medi-Cal Number
5. Vendor Number, name, and address
6. Authorization number
7. Service Code
8. Unit of service, type, code, and rate
9. Amount of claim, month, and year
10. Service amount, month, and year
11. Invoice number

Records maintained at the Regional Center include:

1. Case records
2. Service authorization forms
3. Fiscal submissions to UFS
4. Vendor invoices
5. Vendor attendance records
6. HCBS Waiver service provider agreement

The Regional Centers are required to maintain fiscal records, including authorization forms and vendor invoices, on all Waiver consumers for a period of five years following the month of service. DDS will maintain all UFS files transmitted to DDS for a minimum of five years.

Service providers will be required, via specific provider agreement, to maintain records of funds expended for Waiver services for a minimum of five years following the date of service.

APPENDIX G - FINANCIAL DOCUMENTATION

**APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA**

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g., hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	Total D + D'	FACTOR G	FACTOR G'	Total G + G'
1	<u>\$ 23,060</u>	<u>\$ 9,244</u>	<u>\$ 32,304</u>	<u>\$ 74,249</u>	<u>\$ 5,361</u>	<u>\$ 79,610</u>
2	<u>\$ 23,619</u>	<u>\$ 9,457</u>	<u>\$ 33,076</u>	<u>\$ 73,918</u>	<u>\$ 5,484</u>	<u>\$ 79,402</u>
3	<u>\$ 24,163</u>	<u>\$ 9,675</u>	<u>\$ 33,838</u>	<u>\$ 77,161</u>	<u>\$ 5,610</u>	<u>\$ 82,771</u>
4	<u>\$ 24,718</u>	<u>\$ 9,898</u>	<u>\$ 34,616</u>	<u>\$ 79,625</u>	<u>\$ 5,739</u>	<u>\$ 85,364</u>
5	<u>\$ 25,287</u>	<u>\$ 10,126</u>	<u>\$ 35,413</u>	<u>\$ 82,154</u>	<u>\$ 5,871</u>	<u>\$ 88,025</u>

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	<u>75,000</u>
2	<u>80,000</u>
3	<u>85,000</u>
4	<u>90,000</u>
5	<u>95,000</u>

EXPLANATION OF FACTOR C:

Check one:

The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES
FACTOR D

LOC: ICF/MR

The estimated annual average per capita Medicaid cost for home and community-based service for individuals in the Waiver program **is calculated as follows:**

AVERAGE LENGTH OF STAY (ALOS)

ALOS is calculated by dividing the total number of enrolled days of all waiver participants by the unduplicated recipients reported in the September 30, 2005 CMS 372.

FACTOR D DERIVATION

The Factor D value is estimated on the actual number of users, utilization, and cost per unit reported in the September 30, 2005 CMS 372 trended forward to reflect inflation adjustments and increases in the number of persons who will be served during the renewal period. Utilization adjustments take into account the ALOS calculation above. Inflation adjustments are based on the California Consumer Price Index as reported by the California Department of Finance.

The number of users, utilization, and cost per unit for services added since September 30, 2005 are estimated based on State studies of utilization and costs of the service and/or experience in other states that operate similar HCBS waivers. These services have been previously approved by CMS through amendments to the 2001-2006 waiver agreement.

The demonstration of Factor D estimates is on the following pages.

**APPENDIX G-2
FACTOR D**

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year (1) 2006/07 (2) (3) (4) (5)

Waiver Service Column A	#Updup.Reci (users) Column B	Avg.#Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
A - 1 Homemaker Services	1,165	321.3	\$ 14.18	\$ 5,307,780
A - 2 Home Health Aide Services	3,413	193.75	28.76	19,018,089
A - 3 Respite Care	38,203	153.07	10.87	63,564,860
A - 4 Residential Habilitation for Children	2,261	10.41	2,733.08	64,328,531
A - 5 Day Habitation	56,406	210.66	40.87	485,637,283
A - 6 Prevocational Services	11,241	453	9.66	49,190,391
A - 7 Supported Employment Services	4,964	458.78	10.14	23,092,673
A - 8 Environmental Modifications	102	1.23	6,548.16	821,532
A - 9 Skilled Nursing	1,425	76.98	31.38	3,442,276
A - 10 Transportation	53,203	145.18	13.24	102,265,913
A - 11 Specialized Medical Equip & Supplies	1,141	2.6	678.39	2,012,512
A - 12 Chore	4	218.75	10.40	9,100
A - 13 Personal Emergency Response System	511	10.41	16.56	88,091
A - 14 Family Training	4,694	92.88	16.37	7,136,972
A - 15 Adult Residential	33,021	10.41	2,143.26	736,742,646
A - 16 Vehicle Adaptations	184	1.01	5,334.29	991,324
A - 17 Communication Aides	715	36.69	15.04	394,550
A - 18 Mobile Crisis Intervention	869	23.08	78.99	1,584,265
A - 19 Crisis Intervention Facilities	74	135.94	328.08	3,300,340
A - 20 Nutritional Consultant	575	16.63	24.94	238,483
A - 21 Behavior Intervention Services	7,195	150.4	24.96	27,009,915
A - 22 Specialized Therapeutic Services:				
Oral Health	27	1.02	776.95	21,397
MB/SEBI	12	7.62	104.23	9,531
Physical Health	29	17.34	45.83	23,046
A - 23 Transition/Set Up Expenses	4	1.00	4,092.00	16,368
				\$ 1,596,247,868
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				75,000
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS):				\$ 21,283
AVERAGE LENGTH OF STAY: <u>10.41 Months/Client/Year</u>				

**APPENDIX G-2
FACTOR D**

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year (1) (2) 2007/08 (3) (4) (5)

Waiver Service Column A	#Updup.Reci (users) Column B	Avg.#Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
A - 1 Homemaker Services	1,007	307.73	\$ 19.06	\$ 5,906,391
A - 2 Home Health Aide Services	4,126	10.75	559.80	24,829,649
A - 3 Respite Care	16,045	10.75	232.72	40,140,418
A - 4 Residential Habilitation for Children	2,829	10.75	1,783.59	54,242,093
A - 5 Day Habitation	64,556	10.75	858.06	595,473,905
A - 6 Prevocational Services	18,430	10.75	291.99	57,849,789
A - 7 Supported Employment Services	8,309	10.75	381.88	34,110,190
A - 8 Environmental Modifications	109	1	5,700.37	621,340
A - 9 Skilled Nursing	1,436	10.75	344.06	5,311,254
A - 10 Transportation	68,959	10.75	152.22	112,842,094
A - 11 Specialized Medical Equip & Supplies	1,196	10.75	154.17	1,982,164
A - 12 Chore	15	78.83	196.54	232,399
A - 13 Personal Emergency Response System	574	10.75	15.74	97,124
A - 14 Family Training	4,763	10.75	165.97	8,498,037
A - 15 Adult Residential	39,101	10.75	2,175.95	914,629,575
A - 16 Vehicle Adaptations	196	1	5,649.50	1,107,302
A - 17 Communication Aides	852	10.75	59.71	546,884
A - 18 Mobile Crisis Intervention	979	10.75	160.89	1,693,247
A - 19 Crisis Intervention Facilities	115	10.75	2,588.43	3,199,947
A - 20 Nutritional Consultant	694	10.75	41.53	309,835
A - 21 Behavior Intervention Services	7,327	10.75	321.35	25,311,213
A - 22 Specialized Therapeutic Services:				
Oral Health	254	1.00	757.26	192,344
MB/SEBI	115	18.69	101.59	218,352
Physical Health	269	14.17	44.66	170,232
A - 23 Transition/Set Up Expenses	4	1.00	4,294.95	17,180
				\$ 1,889,532,958
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				80,000
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS):				\$ 23,619
AVERAGE LENGTH OF STAY: <u>10.75 Months/Client/Year</u>				

**APPENDIX G-2
FACTOR D**

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year (1) (2) (3) 2008/09 (4) (5)

Waiver Service Column A	#Updup.Reci (users) Column B	Avg.#Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
A - 1 Homemaker Services	1,070	307.73	\$ 19.50	\$ 6,420,786
A - 2 Home Health Aide Services	4,384	10.75	572.68	26,989,263
A - 3 Respite Care	17,048	10.75	238.07	43,630,137
A - 4 Residential Habilitation for Children	3,006	10.75	1,824.61	58,961,360
A - 5 Day Habitation	68,591	10.75	877.80	647,248,683
A - 6 Prevocational Services	19,582	10.75	298.71	62,880,397
A - 7 Supported Employment Services	8,828	10.75	390.66	37,074,025
A - 8 Environmental Modifications	116	1	5,831.48	676,452
A - 9 Skilled Nursing	1,526	10.75	351.97	5,773,892
A - 10 Transportation	73,269	10.75	155.72	122,651,573
A - 11 Specialized Medical Equip & Supplies	1,271	10.75	157.72	2,154,968
A - 12 Chore	16	78.83	201.06	253,593
A - 13 Personal Emergency Response System	610	10.75	16.10	105,576
A - 14 Family Training	5,061	10.75	169.79	9,237,552
A - 15 Adult Residential	41,545	10.75	2,226.00	994,151,078
A - 16 Vehicle Adaptations	208	1	5,779.44	1,202,124
A - 17 Communication Aides	905	10.75	61.08	594,232
A - 18 Mobile Crisis Intervention	1,040	10.75	164.59	1,840,116
A - 19 Crisis Intervention Facilities	122	10.75	2,647.96	3,472,800
A - 20 Nutritional Consultant	737	10.75	42.49	336,638
A - 21 Behavior Intervention Services	7,785	10.75	328.74	27,511,840
A - 22 Specialized Therapeutic Services:				
Oral Health	270	1.00	774.68	209,164
MB/SEBI	122	18.69	103.93	236,979
Physical Health	286	14.17	45.69	185,164
A - 23 Transition/Set Up Expenses	4	1.00	4,393.73	17,575
				\$ 2,053,815,967
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				85,000
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS):				\$ 24,163
AVERAGE LENGTH OF STAY: <u>10.75 Months/Client/Year</u>				

**APPENDIX G-2
FACTOR D**

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year (1) (2) (3) (4) 2009/10 (5)

Waiver Service Column A	#Updup.Reci (users) Column B	Avg.#Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
A - 1 Homemaker Services	1,133	307.73	\$ 19.95	\$ 6,955,729
A - 2 Home Health Aide Services	4,642	10.75	585.85	29,234,794
A - 3 Respite Care	18,051	10.75	243.55	47,260,451
A - 4 Residential Habilitation for Children	3,183	10.75	1,866.58	63,869,235
A - 5 Day Habitation	72,626	10.75	897.99	701,087,284
A - 6 Prevocational Services	20,734	10.75	305.58	68,110,879
A - 7 Supported Employment Services	9,347	10.75	399.65	40,156,932
A - 8 Environmental Modifications	123	1	5,965.60	733,769
A - 9 Skilled Nursing	1,616	10.75	360.07	6,255,136
A - 10 Transportation	77,579	10.75	159.30	132,852,098
A - 11 Specialized Medical Equip & Supplies	1,346	10.75	161.35	2,334,654
A - 12 Chore	17	78.83	205.68	275,634
A - 13 Personal Emergency Response System	646	10.75	16.47	114,376
A - 14 Family Training	5,359	10.75	173.70	10,006,727
A - 15 Adult Residential	43,989	10.75	2,277.20	1,076,846,321
A - 16 Vehicle Adaptations	220	1	5,912.37	1,300,721
A - 17 Communication Aides	958	10.75	62.48	643,450
A - 18 Mobile Crisis Intervention	1,101	10.75	168.38	1,992,904
A - 19 Crisis Intervention Facilities	129	10.75	2,708.86	3,756,512
A - 20 Nutritional Consultant	780	10.75	43.47	364,496
A - 21 Behavior Intervention Services	8,243	10.75	336.30	29,800,300
A - 22 Specialized Therapeutic Services:				
Oral Health	286	1.00	792.50	226,655
MB/SEBI	129	18.69	106.32	256,339
Physical Health	303	14.17	46.74	200,679
A - 23 Transition/Set Up Expenses	4	1.00	4,494.79	17,979
				\$ 2,224,654,054
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				<u>90,000</u>
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS):				\$ 24,718
AVERAGE LENGTH OF STAY: <u>10.75 Months/Client/Year</u>				

**APPENDIX G-2
FACTOR D**

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year (1) (2) (3) (4) (5) 2010/11

Waiver Service Column A	#Updup.Reci (users) Column B	Avg.#Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
A - 1 Homemaker Services	1,196	307.73	\$ 20.41	\$ 7,511,800
A - 2 Home Health Aide Services	4,900	10.75	599.32	31,569,181
A - 3 Respite Care	19,054	10.75	249.15	51,033,519
A - 4 Residential Habilitation for Children	3,360	10.75	1,909.51	68,971,501
A - 5 Day Habitation	76,661	10.75	918.64	757,056,506
A - 6 Prevocational Services	21,886	10.75	312.61	73,549,161
A - 7 Supported Employment Services	9,866	10.75	408.84	43,361,366
A - 8 Environmental Modifications	130	1	6,102.81	793,365
A - 9 Skilled Nursing	1,706	10.75	368.35	6,755,355
A - 10 Transportation	81,889	10.75	162.96	143,454,788
A - 11 Specialized Medical Equip & Supplies	1,421	10.75	165.06	2,521,415
A - 12 Chore	18	78.83	210.41	298,559
A - 13 Personal Emergency Response System	682	10.75	16.85	123,536
A - 14 Family Training	5,657	10.75	177.70	10,806,426
A - 15 Adult Residential	46,433	10.75	2,329.58	1,162,820,923
A - 16 Vehicle Adaptations	232	1	6,048.35	1,403,217
A - 17 Communication Aides	1,011	10.75	63.92	694,699
A - 18 Mobile Crisis Intervention	1,162	10.75	172.25	2,151,661
A - 19 Crisis Intervention Facilities	136	10.75	2,771.16	4,051,436
A - 20 Nutritional Consultant	823	10.75	44.47	393,437
A - 21 Behavior Intervention Services	8,701	10.75	344.03	32,179,104
A - 22 Specialized Therapeutic Services:				
Oral Health	302	1.00	810.73	244,840
MB/SEBI	136	18.69	108.77	276,476
Physical Health	320	14.17	47.82	216,835
A - 23 Transition/Set Up Expenses	4	1.00	4,598.17	18,393
				\$ 2,402,257,499
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS				95,000
FACTOR D (DIVIDE TOTAL BY NUMBER OF RECIPIENTS):				\$ 25,287
AVERAGE LENGTH OF STAY: <u>10.75 Months/Client/Year</u>				

ATTACHMENT TO APPENDIX G -2

METHODOLOGY FOR DERIVATION OF FORMULA VALUES DEMONSTRATION OF FACTOR D ESTIMATES

The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the Waiver program was estimated as follows:

Existing Waiver services

For existing Waiver services, the actual expenditures as reported on the CMS 372 (S) for Fiscal Year **2003/04** for the per capita cost by service was used and **trended** forward using a cost of living factor of **three and four tenths percent for 2004/05, two and six-tenths for 2005/06, and two and three-tenths for 2006/07 and thereafter..**

New Waiver services

For proposed new services, actual expenditures for Fiscal Year **2003/04** were **trended** forward using a cost of living factor of **three and four tenths percent for 2004/05, two and six-tenths for 2005/06, and two and three-tenths for 2006/07 and thereafter..**

Eligible Recipients

The number of eligible recipients was estimated by starting in year one with **75,000** ~~**the last approved number or recipients**~~ and increasing regional center caseload to **80,000** in year 2, **85,000** in year 3, **90,000** in year 4, and **95,000** in year 5. Estimates of eligible recipients by service for each proposed year of the Waiver were based on the ratio of **the** actual **unduplicated number of** recipients of **each** service to the total **number of unduplicated recipients of service** for Fiscal Year **2004/05**.

**UNIT COST DISTRIBUTION OF FORMULA:
FACTOR D**

WAIVER SERVICES	Unit	Recipients					Units Per Recipient					
		WY	WY	WY	WY	WY	WY	WY	WY	WY		
		01	02	03	04	05	01	02	03	04	05	
A - 1	Homemaker Services	Hour	<u>1,165</u>	<u>1,243</u>	<u>1,321</u>	<u>1,399</u>	<u>1,477</u>	<u>321.30</u>	<u>321.30</u>	<u>321.30</u>	<u>321.30</u>	<u>321.30</u>
A - 2	Home Health Aide Svcs	Hour	<u>3,413</u>	<u>3,641</u>	<u>3,869</u>	<u>4,097</u>	<u>4,325</u>	<u>193.75</u>	<u>193.75</u>	<u>193.75</u>	<u>193.75</u>	<u>193.75</u>
A - 3	Respite Care	Hour	<u>38,203</u>	<u>40,750</u>	<u>43,297</u>	<u>45,844</u>	<u>48,391</u>	<u>153.07</u>	<u>153.07</u>	<u>153.07</u>	<u>153.07</u>	<u>153.07</u>
A - 4	Res. Habil. for Children	Month	<u>2,261</u>	<u>2,412</u>	<u>2,563</u>	<u>2,714</u>	<u>2,865</u>	<u>10.41</u>	<u>10.41</u>	<u>10.41</u>	<u>10.41</u>	<u>10.41</u>
A - 5	Day Habitation	Day	<u>56,406</u>	<u>60,166</u>	<u>63,926</u>	<u>67,686</u>	<u>71,446</u>	<u>210.66</u>	<u>210.66</u>	<u>210.66</u>	<u>210.66</u>	<u>210.66</u>
A - 6	Prevocational Services	Hour	<u>11,241</u>	<u>11,990</u>	<u>12,739</u>	<u>13,488</u>	<u>14,237</u>	<u>453.00</u>	<u>453.00</u>	<u>453.00</u>	<u>453.00</u>	<u>453.00</u>
A - 7	Supported Emplmnt Svcs	Hour	<u>4,964</u>	<u>5,295</u>	<u>5,626</u>	<u>5,957</u>	<u>6,288</u>	<u>458.78</u>	<u>458.78</u>	<u>458.78</u>	<u>458.78</u>	<u>458.78</u>
A - 8	Environ. Modifications	Modification	<u>102</u>	<u>109</u>	<u>116</u>	<u>123</u>	<u>130</u>	<u>1.23</u>	<u>1.23</u>	<u>1.23</u>	<u>1.23</u>	<u>1.23</u>
A - 9	Skilled Nursing	Hour	<u>1,425</u>	<u>1,520</u>	<u>1,615</u>	<u>1,710</u>	<u>1,805</u>	<u>76.98</u>	<u>76.98</u>	<u>76.98</u>	<u>76.98</u>	<u>76.98</u>
A - 10	Transportation	Day	<u>53,203</u>	<u>56,750</u>	<u>60,297</u>	<u>63,844</u>	<u>67,391</u>	<u>145.18</u>	<u>145.18</u>	<u>145.18</u>	<u>145.18</u>	<u>145.18</u>
A - 11	Spec. Med Equip & Sup	Piece	<u>1,141</u>	<u>1,217</u>	<u>1,293</u>	<u>1,369</u>	<u>1,445</u>	<u>2.60</u>	<u>2.60</u>	<u>2.60</u>	<u>2.60</u>	<u>2.60</u>
A - 12	Chore	Hour	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>218.75</u>	<u>218.75</u>	<u>218.75</u>	<u>218.75</u>	<u>218.75</u>
A - 13	Pers Emerg Resp Sys	Month	<u>511</u>	<u>545</u>	<u>579</u>	<u>613</u>	<u>647</u>	<u>10.41</u>	<u>10.41</u>	<u>10.41</u>	<u>10.41</u>	<u>10.41</u>
A - 14	Family Training	Hour	<u>4,694</u>	<u>5,007</u>	<u>5,320</u>	<u>5,633</u>	<u>5,946</u>	<u>92.88</u>	<u>92.88</u>	<u>92.88</u>	<u>92.88</u>	<u>92.88</u>
A - 15	Adult Residential	Month	<u>33,021</u>	<u>35,222</u>	<u>37,423</u>	<u>39,624</u>	<u>41,825</u>	<u>10.41</u>	<u>10.41</u>	<u>10.41</u>	<u>10.41</u>	<u>10.41</u>
A - 16	Vehicle Adaptations	Modification	<u>184</u>	<u>196</u>	<u>208</u>	<u>220</u>	<u>232</u>	<u>1.01</u>	<u>1.01</u>	<u>1.01</u>	<u>1.01</u>	<u>1.01</u>
A - 17	Communication Aides	Hour	<u>715</u>	<u>763</u>	<u>811</u>	<u>859</u>	<u>907</u>	<u>36.69</u>	<u>36.69</u>	<u>36.69</u>	<u>36.69</u>	<u>36.69</u>
A - 18	Mobile Crisis Inter	Hour	<u>869</u>	<u>927</u>	<u>985</u>	<u>1,043</u>	<u>1,101</u>	<u>23.08</u>	<u>23.08</u>	<u>23.08</u>	<u>23.08</u>	<u>23.08</u>
A - 19	Crisis Interv. Facilities	Day	<u>74</u>	<u>79</u>	<u>84</u>	<u>89</u>	<u>94</u>	<u>135.94</u>	<u>135.94</u>	<u>135.94</u>	<u>135.94</u>	<u>135.94</u>
A - 20	Nutritional Consultant	Hour	<u>575</u>	<u>613</u>	<u>651</u>	<u>689</u>	<u>727</u>	<u>16.63</u>	<u>16.63</u>	<u>16.63</u>	<u>16.63</u>	<u>16.63</u>
A - 21	Behavior Intervention Svcs	Hour	<u>7,195</u>	<u>7,675</u>	<u>8,155</u>	<u>8,635</u>	<u>9,115</u>	<u>150.40</u>	<u>150.40</u>	<u>150.40</u>	<u>150.40</u>	<u>150.40</u>
A - 22	Spec. Therap. Svcs:											
	Oral Health	Visit	<u>27</u>	<u>29</u>	<u>31</u>	<u>33</u>	<u>35</u>	<u>1.02</u>	<u>1.02</u>	<u>1.02</u>	<u>1.02</u>	<u>1.02</u>
	MB/SEBI	Hour	<u>12</u>	<u>13</u>	<u>14</u>	<u>15</u>	<u>16</u>	<u>7.62</u>	<u>7.62</u>	<u>7.62</u>	<u>7.62</u>	<u>7.62</u>
	Physical Health	Hour	<u>29</u>	<u>31</u>	<u>33</u>	<u>35</u>	<u>37</u>	<u>17.34</u>	<u>17.34</u>	<u>17.34</u>	<u>17.34</u>	<u>17.34</u>
A-23	Transition/Set Up Expenses	One-Time	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>1.00</u>	<u>1.00</u>	<u>1.00</u>	<u>1.00</u>	<u>1.00</u>

**UNIT COST DISTRIBUTION OF FORMULA:
FACTOR D (continued)**

WAIVER SERVICES	Unit	Average Unit Cost					Estimated Costs (in thousands)					
		WY	WY	WY	WY	WY	WY	WY	WY	WY		
		01	02	03	04	05	01	02	03	04	05	
A - 1	Homemaker Services	Hour	<u>\$14.18</u>	<u>\$14.51</u>	<u>\$14.84</u>	<u>\$15.18</u>	<u>\$15.53</u>	<u>\$5,308</u>	<u>\$5,795</u>	<u>\$6,299</u>	<u>\$6,823</u>	<u>\$7,370</u>
A - 2	Home Health Aide Svcs	Hour	<u>\$28.76</u>	<u>\$29.42</u>	<u>\$30.10</u>	<u>\$30.79</u>	<u>\$31.50</u>	<u>\$19,018</u>	<u>\$20,754</u>	<u>\$22,564</u>	<u>\$24,441</u>	<u>\$26,396</u>
A - 3	Respite Care	Hour	<u>\$10.87</u>	<u>\$11.12</u>	<u>\$11.38</u>	<u>\$11.64</u>	<u>\$11.91</u>	<u>\$63,565</u>	<u>\$69,362</u>	<u>\$75,421</u>	<u>\$81,682</u>	<u>\$88,220</u>
A - 4	Res. Habil. for Children	Month	<u>\$2,733.08</u>	<u>\$2,795.94</u>	<u>\$2,860.25</u>	<u>\$2,926.04</u>	<u>\$2,993.34</u>	<u>\$64,329</u>	<u>\$70,203</u>	<u>\$76,314</u>	<u>\$82,669</u>	<u>\$89,275</u>
A - 5	Day Habitation	Day	<u>\$40.87</u>	<u>\$41.81</u>	<u>\$42.77</u>	<u>\$43.75</u>	<u>\$44.76</u>	<u>\$485,637</u>	<u>\$529,924</u>	<u>\$575,969</u>	<u>\$623,820</u>	<u>\$673,674</u>
A - 6	Prevocational Services	Hour	<u>\$9.66</u>	<u>\$9.88</u>	<u>\$10.11</u>	<u>\$10.34</u>	<u>\$10.58</u>	<u>\$49,190</u>	<u>\$53,663</u>	<u>\$58,342</u>	<u>\$63,178</u>	<u>\$68,234</u>
A - 7	Supported Emplmnt Svcs	Hour	<u>\$10.14</u>	<u>\$10.37</u>	<u>\$10.61</u>	<u>\$10.85</u>	<u>\$11.10</u>	<u>\$23,093</u>	<u>\$25,191</u>	<u>\$27,385</u>	<u>\$29,653</u>	<u>\$32,021</u>
A - 8	Environ. Modifications	Modification	<u>\$6,548.16</u>	<u>\$6,698.77</u>	<u>\$6,852.84</u>	<u>\$7,010.46</u>	<u>\$7,171.70</u>	<u>\$822</u>	<u>\$898</u>	<u>\$978</u>	<u>\$1,061</u>	<u>\$1,147</u>
A - 9	Skilled Nursing	Hour	<u>\$31.38</u>	<u>\$32.10</u>	<u>\$32.84</u>	<u>\$33.60</u>	<u>\$34.37</u>	<u>\$3,442</u>	<u>\$3,756</u>	<u>\$4,083</u>	<u>\$4,423</u>	<u>\$4,776</u>
A - 10	Transportation	Day	<u>\$13.24</u>	<u>\$13.54</u>	<u>\$13.85</u>	<u>\$14.17</u>	<u>\$14.50</u>	<u>\$102,266</u>	<u>\$111,556</u>	<u>\$121,242</u>	<u>\$131,340</u>	<u>\$141,865</u>
A - 11	Spec. Med Equip & Sup	Piece	<u>\$678.39</u>	<u>\$693.99</u>	<u>\$709.95</u>	<u>\$726.28</u>	<u>\$742.98</u>	<u>\$2,013</u>	<u>\$2,196</u>	<u>\$2,387</u>	<u>\$2,585</u>	<u>\$2,791</u>
A - 12	Chore	Hour	<u>\$10.40</u>	<u>\$10.64</u>	<u>\$10.88</u>	<u>\$11.13</u>	<u>\$11.39</u>	<u>\$9</u>	<u>\$9</u>	<u>\$10</u>	<u>\$10</u>	<u>\$10</u>
A - 13	Pers Emerg Resp Sys	Month	<u>\$16.56</u>	<u>\$16.94</u>	<u>\$17.33</u>	<u>\$17.73</u>	<u>\$18.14</u>	<u>\$88</u>	<u>\$96</u>	<u>\$104</u>	<u>\$113</u>	<u>\$122</u>
A - 14	Family Training	Hour	<u>\$16.37</u>	<u>\$16.75</u>	<u>\$17.14</u>	<u>\$17.53</u>	<u>\$17.93</u>	<u>\$7,137</u>	<u>\$7,790</u>	<u>\$8,469</u>	<u>\$9,172</u>	<u>\$9,902</u>
A - 15	Adult Residential	Month	<u>\$2,143.26</u>	<u>\$2,163.51</u>	<u>\$2,207.08</u>	<u>\$2,257.84</u>	<u>\$2,309.77</u>	<u>\$736,743</u>	<u>\$793,275</u>	<u>\$859,820</u>	<u>\$931,327</u>	<u>\$1,005,670</u>
A - 16	Vehicle Adaptations	Modification	<u>\$5,334.29</u>	<u>\$5,456.98</u>	<u>\$5,582.49</u>	<u>\$5,710.89</u>	<u>\$5,842.24</u>	<u>\$991</u>	<u>\$1,080</u>	<u>\$1,173</u>	<u>\$1,269</u>	<u>\$1,369</u>
A - 17	Communication Aides	Hour	<u>\$15.04</u>	<u>\$15.39</u>	<u>\$15.74</u>	<u>\$16.10</u>	<u>\$16.47</u>	<u>\$395</u>	<u>\$431</u>	<u>\$468</u>	<u>\$507</u>	<u>\$548</u>
A - 18	Mobile Crisis Inter	Hour	<u>\$78.99</u>	<u>\$80.81</u>	<u>\$82.67</u>	<u>\$84.57</u>	<u>\$86.52</u>	<u>\$1,584</u>	<u>\$1,729</u>	<u>\$1,879</u>	<u>\$2,036</u>	<u>\$2,199</u>
A - 19	Crisis Interv. Facilities	Day	<u>\$328.08</u>	<u>\$335.63</u>	<u>\$343.35</u>	<u>\$351.25</u>	<u>\$359.33</u>	<u>\$3,300</u>	<u>\$3,604</u>	<u>\$3,921</u>	<u>\$4,250</u>	<u>\$4,592</u>
A - 20	Nutritional Consultant	Hour	<u>\$24.94</u>	<u>\$25.51</u>	<u>\$26.10</u>	<u>\$26.70</u>	<u>\$27.31</u>	<u>\$238</u>	<u>\$260</u>	<u>\$283</u>	<u>\$306</u>	<u>\$330</u>
A - 21	Behavior Intervention Svcs	Hour	<u>\$24.96</u>	<u>\$25.53</u>	<u>\$26.12</u>	<u>\$26.72</u>	<u>\$27.33</u>	<u>\$27,010</u>	<u>\$29,470</u>	<u>\$32,036</u>	<u>\$34,701</u>	<u>\$37,467</u>
A - 22	Spec. Therap. Svcs:											
	Oral Health	Visit	<u>\$776.95</u>	<u>\$794.82</u>	<u>\$813.10</u>	<u>\$831.80</u>	<u>\$850.93</u>	<u>\$21</u>	<u>\$24</u>	<u>\$26</u>	<u>\$28</u>	<u>\$30</u>
	MB/SEBI	Hour	<u>\$104.23</u>	<u>\$106.63</u>	<u>\$109.08</u>	<u>\$111.59</u>	<u>\$114.16</u>	<u>\$10</u>	<u>\$11</u>	<u>\$12</u>	<u>\$13</u>	<u>\$14</u>
	Physical Health	Hour	<u>\$45.83</u>	<u>\$46.88</u>	<u>\$47.96</u>	<u>\$49.06</u>	<u>\$50.19</u>	<u>\$23</u>	<u>\$25</u>	<u>\$27</u>	<u>\$30</u>	<u>\$32</u>
A-23	Transition/Set Up Expenses	One-Time	<u>\$4,092.00</u>	<u>\$4,186.12</u>	<u>\$4,282.40</u>	<u>\$4,380.90</u>	<u>\$4,481.66</u>	<u>\$16</u>	<u>\$17</u>	<u>\$17</u>	<u>\$18</u>	<u>\$18</u>

APPENDIX G -3**METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD**

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the Waiver.

- A. The following service(s), other than respite care *, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Day Habilitation, Transportation, Specialized Medical Equipment and Supplies, Residential Care, Home Health Aide, Intermittent Skilled Nursing, Communication Aides, and Nutritional Consultation.

NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this Waiver.

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Homemaker, Home Health Aide, Respite, Environmental Adaptations, Skilled Nursing, Transportation, Specialized Medical Equipment and Supplies, Chore, Communication Aides, Mobile Crisis Intervention, Vehicle Adaptations, and Nutritional Consultation.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

ATTACHMENT TO APPENDIX G -3**METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD**

In California, the Alternative Residential Model Rates Schedule (ARMS) establishes maximum rates for community care residential facilities. The basic rate constitutes the provision of shelter, meals, housekeeping (room and board), and is equivalent to the SSI/SSP rate. Amounts claimed above the SSI/SSP rate cover services provided to clients which assist them in maintaining community placement by meeting their individual needs. Thus, the room and board amount (SSI/SSP rate) is subtracted from the claim leaving a net claim for service to the State.

The Medicaid Waiver billing system automatically verifies that the amount claimed **for all HCBS Waiver billable community care licensed facility services** is netted. ~~Any claim that exceeds the ARMS rate less the SSI/SSP amount is suspended from the Medicaid Waiver bill.~~

APPENDIX G -4**METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER**

Check one:

- The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) serviced on the Waiver.
- The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the Waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of Waiver services) in Appendix G-2 of this Waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the Waiver.

ATTACHMENT TO APPENDIX G -4**METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER**

The following estimates are based on the **2006** Fair Market Rent (FMR) used by HUD for two-bedroom housing, the mean of those rents, and the maximum food stamp allowance for one person. See attachments for rent detail.

½Mean rent ¹	\$	<u>412</u>
Board ²		<u>132</u>
Total	\$	<u>544</u>
Consumers receiving Supported Living Services ³		
		<u>4,000</u>
15% of those have live-in/overnight Services		
		<u>600</u>
Mean room & board cost	\$	<u>544</u>
No. With live-in/overnight service	x	<u>600</u>
Potential monthly Waiver billing		<u>\$326,400</u>

¹ Rent includes utilities, except for telephone.

² Based on the maximum food stamp allowance for one person.

³ Based on number of consumers receiving services under supported living services.

MEAN RENTAL COSTS
California **2006**
HUD Fair Market Rents (FMR) for Existing Housing
Two-Bedroom Housing

Metropolitan FMR Areas

Bakersfield	<u>\$604</u>
Chico/Paradise	<u>\$656</u>
Fresno	<u>\$615</u>
Los Angeles/Long Beach	<u>\$1,124</u>
Merced	<u>\$615</u>
Modesto	<u>\$710</u>
Oakland	<u>\$1,342</u>
Orange County	<u>\$1,317</u>
Redding	<u>\$636</u>
Riverside/San Bernadino	<u>\$803</u>
Sacramento	<u>\$976</u>
Salinas	<u>\$1,035</u>
San Diego	<u>\$1,183</u>
San Francisco	<u>\$1,539</u>
San Jose	<u>\$1,305</u>
San Luis Obispo/Atascadero/ Paso Robles	<u>\$893</u>
Santa Barbara/Santa Maria/ Lompoc	<u>\$1,004</u>
Santa Cruz/Watsonville	<u>\$1,347</u>
Santa Rosa	<u>\$1,154</u>
Stockton/Lodi	<u>\$734</u>
Vallejo/Fairfield/Napa	<u>\$986</u>
Ventura/ <u>Oxnard/Thousand Oaks</u>	<u>\$1,382</u>
Visalia/Tulare/Porterville	<u>\$605</u>
Yolo	<u>\$851</u>
Yuba City	<u>\$587</u>

TOTAL - Metropolitan	<u>\$24,003</u>
Mean	<u>\$960</u>
Median	<u>\$976</u>

Total / drop 3 high, 3 low	<u>\$17,939</u>
Mean	<u>\$944</u>
Median	<u>\$976</u>

TOTAL - Metro/Nonmetro	<u>\$40,370</u>
Mean	<u>\$824</u>

Non-metropolitan Counties

Alpine	<u>\$713</u>
Amador	<u>\$826</u>
Calaveras	<u>\$638</u>
Colousa	<u>\$632</u>
Del Norte	<u>\$621</u>
Glenn	<u>\$559</u>
Humboldt	<u>\$678</u>
Imperial	<u>\$636</u>
Inyo	<u>\$613</u>
Kings	<u>\$592</u>
Lake	<u>\$664</u>
Lassen	<u>\$652</u>
Mariposa	<u>\$690</u>
Mendocino	<u>\$729</u>
Modoc	<u>\$607</u>
Mono	<u>\$872</u>
Nevada	<u>\$838</u>
Plumas	<u>\$665</u>
San Benito	<u>\$887</u>
Sierra	<u>\$785</u>
Siskiyou	<u>\$577</u>
Tehama	<u>\$585</u>
Trinity	<u>\$588</u>
Tuolumne	<u>\$720</u>

TOTAL - Nonmetropolitan	<u>\$16,367</u>
Mean	<u>\$682</u>
Median	<u>\$652</u>

Total / drop 3 high, 3 low	<u>\$12,049</u>
Mean	<u>\$669</u>
Median	<u>\$652</u>

TOTAL / drop 3 high, 3 low	<u>\$29,988</u>
Mean	<u>\$810</u>
Median	<u>\$713</u>

**APPENDIX G-5
FACTOR D'**

LOC: ICF/MR

NOTICE: On July 25, 1994, CMS published regulations which changed the definition of Factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the Waiver program."

Factor D' includes the following:

The cost of all State plan services (including home health, personal care, and adult day health care) furnished in addition to Waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of Waiver services and ended BEFORE the end of the Waiver year IF the person returned to the Waiver.

Factor D' does not include the following:

The costs of institutional care, if the person did NOT return to the Waiver following institutionalization.

Institutional costs incurred BEFORE the person is first served under the Waiver in this Waiver year.

Costs for institutional respite care provided as a service under this Waiver. Such costs are included in the calculation of costs under Factor D

Costs of prescription drugs furnished to Medicare/Medicaid dual eligibles, in compliance with Part D. Such costs have been removed from the baseline figures reported in the September 30, 2004 CMS 372 used to calculate Factor D'. The data was identified through an analysis of the State's Medicaid system done by the Single State Agency.

**APPENDIX G-5
FACTOR D' (cont.)**

LOC: ICF/MR

Factor D'; is computed as follows (check one):

- Based on CMS Form 2082 (relevant pages attached).
- Based on CMS form 372 for years _____ of Waiver # _____, which serves a similar target population.
- Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.
- Other (specify):

This number is derived from the actual CMS 372 (S), Section III, for Fiscal Year 2003/04. This factor is adjusted for cost of living, which is applied over the Waiver period. See attachment.

ATTACHMENT TO APPENDIX G-5

COMMUNITY BASED SERVICES ACUTE CARE CALCULATIONS: FACTOR D'

HCFA 372 Report Service Category	a FY 2004/05 Actual Costs	Projected Annual Costs					
		FY 2005/06	FY 2006/07	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11
A.1. Inpatient Hospital	\$ 29,157,761	\$ 33,445,103	\$ 36,658,342	\$ 39,001,143	\$ 41,432,624	\$ 43,954,563	\$ 46,569,260
A.2. Physicians	8,574,573	9,835,374	10,780,308	11,469,268	12,184,306	12,925,946	13,694,864
A.3. Outpatient	8,543,186	9,799,372	10,740,847	11,427,285	12,139,706	12,878,631	13,644,734
A.4. Lab/X-Ray	1,963,500	2,252,212	2,468,593	2,626,358	2,790,095	2,959,924	3,135,999
A.5. Drugs	b 75,815,121	86,962,937	95,317,903	101,409,582	107,731,844	114,289,313	121,087,969
A.6. Other	410,719,594	471,111,590	516,373,644	549,374,606	583,624,725	619,149,051	655,979,980
	\$ 534,773,735	\$ 613,406,588	\$ 672,339,636	\$ 715,308,240	\$ 759,903,298	\$ 806,157,426	\$ 854,112,804
	c						
Unduplicated Clients	58,688	65,612	70,299	73,110	75,922	78,734	81,546
Annual Per Capita	\$ 9,112	\$ 9,349	\$ 9,564	\$ 9,784	\$ 10,009	\$ 10,239	\$ 10,474
Total Factor D'	\$ 9,112	\$ 9,349	\$ 9,564	\$ 9,784	\$ 10,009	\$ 10,239	\$ 10,474

a. Actual costs, DHS HCFA 372, 10/1/03 to 9/30/04. Section VIII.

b. Prescription drugs purchased for dual eligible persons on the Waiver are excluded.

c. Total unduplicated recipients, DHS HCFA 372, 10/1/04 to 9/30/05. Worksheet Section VII, B.1.

d. Inflation adjustment based on California Consumer Price Index per Department of Finance Website:

2005-06 2.6%

2006-07 and later 2.3%

**APPENDIX G-6
FACTOR G**

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

“The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the Waiver, were the Waiver not granted.”

Provide data ONLY for the level(s) of care indicated in item 2 of this Waiver request.

Factor G is computed as follows:

- Based on institutional cost trends shown by CMS Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- Based on ~~trends shown by~~ actual costs in the CMS 372 for year 2004/05 of Waiver #0336, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers. See attachment.
- Based on actual case histories of individuals institutionalized for this disease or condition at this LOC. Documentation attached.
- Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- Other (specify):

If institutional respite care is provided as a service under this Waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

**ATTACHMENT TO APPENDIX G-6
FACTOR G**

MEDICAID RECIPIENTS AND REIMBURSEMENT PROJECTIONS: FACTOR G

Factor F - Medical Care Recipients - ICF/MR

	FY 2003/04 (a)(b)	FY 2004/05 (a)(b)	FY 2005-06	FY 2006-07	FY 2007/08 (f)	FY 2008-09	FY 2009-10	FY 2010-11
Developmental Centers	2,460	1,976	1,931	1,887	1,747	1,611	1,574	1,539
Community Care Fac	7,004	6,967	6,930	6,893	6,857	6,821	6,785	6,749
Sub-total	9,464	8,943	8,861	8,780	8,604	8,432	8,359	8,288
Plus Factor C	60,000	65,000	70,000	75,000	78,000	81,000	84,000	87,000
Total Factor F	69,464	73,943	78,861	83,780	86,604	89,432	92,359	95,288

Factor G - Medical Reimbursement

Annual Costs	FY 2003/04 (c)(d)	FY 2004/05 (c)(d)	FY 2005/06	FY 2006-07	FY 2007/08 (f)	FY 2008/09	FY 2009/10	FY 2010/11
Developmental Centers	\$ 446,807,922	\$ 456,672,778	\$ 468,546,270	\$ 479,322,834	\$ 459,439,188	\$ 470,006,289	\$ 480,816,434	\$ 491,875,212
Community Care Fac	159,020,612	164,427,313	168,702,423	172,582,579	176,551,978	180,612,673	184,766,764	189,016,400
Total	\$ 605,828,534	\$ 621,100,091	\$ 637,248,693	\$ 651,905,413	\$ 635,991,166	\$ 650,618,962	\$ 665,583,198	\$ 680,891,612

Per Annum Costs

Developmental Centers	\$ 181,629	\$ 231,110	\$ 242,644	\$ 254,013	\$ 262,988	\$ 291,748	\$ 305,474	\$ 319,607
Community Care Fac	22,704	23,601	24,344	25,037	25,748	26,479	27,232	28,007
Average	\$ 64,014	\$ 69,451	\$ 71,916	\$ 74,249	\$ 73,918	\$ 77,161	\$ 79,625	\$ 82,154

- (a) State Developmental Center Cost Reporting System - Actual clients billed.
- (b) DDS, Community Services Division, Regional Center Branch ICF Facilities by Regional Center database.
- (c) State Developmental Center Reporting System - Actual costs billed.
- (d) HCFA 372 Report, 10/01/03 to 09/30/04, (Report CM-HCW013-R02) Worksheet Section I, Line B.1., and Worksheet Section II, Line A.1, a., b.
- (e) Inflation adjustment based on California Consumer Price Index per California Department of Finance Website:
 - 2004-05 3.4%
 - 2005-06 2.6%
 - 2006-07 and later 2.3%
- (f) Agnews Developmental Center closes effective 7/1/2008.

**APPENDIX G-7
FACTOR G'****LOC: ICF/MR**

The July 25, 1994 final regulation defines Factor G' as:

“The estimated annual average per capita Medicaid cost for all services other than those included in Factor G for individuals served in the Waiver, were the Waiver not granted.”

Included in Factor G' are the following:

The cost of all State plan services furnished while the individual was institutionalized.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution), which began after the person's first day of institutional services.

Costs of institutional respite care are provided as a service under this Waiver under Factor D. Such costs are not duplicated in the calculation of Factor G'.

Factor G' is computed as follows (check one):

- Based on CMS Form 2082 (relevant pages attached).
- Based on CMS 372 for year **2003/04** of Waiver #0336, which serves a similar target population. See attachment.
- Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.
- Other (specify):

**ATTACHMENT TO APPENDIX G-7
FACTOR G'**

INSTITUTIONAL LONG-TERM ACUTE CARE CALCULATIONS: FACTOR G'

HCFA 372 Report Service Category	Actual Costs			Projected Annual Costs			
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
A.1. Inpatient Hospital	\$ 7,778,769	\$ 7,726,351	\$ 7,651,845	\$ 7,576,345	\$ 7,502,342	\$ 7,429,188	\$ 7,356,999
A.2. Physicians	2,077,335	2,063,337	2,043,440	2,023,277	2,003,514	1,983,979	1,964,701
A.3. Outpatient	1,311,034	1,302,199	1,289,642	1,276,918	1,264,445	1,252,116	1,239,949
A.4. Lab/X-Ray	444,142	441,149	436,895	432,584	428,359	424,182	420,060
A.5. Drugs	d 7,962,577	7,908,920	7,832,653	7,755,370	7,679,617	7,604,736	7,530,841
A.6. Other	15,872,221	15,765,264	15,613,237	15,459,185	15,308,183	15,158,918	15,011,619
	a						
	\$ 35,446,078	\$ 35,207,221	\$ 34,867,712	\$ 34,523,680	\$ 34,186,460	\$ 33,853,120	\$ 33,524,170
	b						
Unduplicated Clients: A'	11,201	10,843	10,496	10,160	9,835	9,520	9,215
Annual Per Capita: B'&G'	\$ 3,165	\$ 3,247	\$ 3,322	\$ 3,398	\$ 3,476	\$ 3,556	\$ 3,638

a. Actual costs, HCFA 372, 10/1/04 to 9/30/05. (DHS report CM-HCW013-R04). Worksheet Section IV, A.1.a.,b., through A.6.a.,b.

b. Total unduplicated recipients, HCFA 372, 10/1/04 to 9/30/05. (DHS report CM-HCW013-R04) . Worksheet Section III, B.1.

c. Inflation adjustment based on California Consumer Price Index per California Department of Finance Website:

2005-06 2.6%

2006-07 and later 2.3%

d. Prescription drugs purchased for dual eligible persons on the Waiver are excluded.

**APPENDIX G-8
DEMONSTRATION OF COST NEUTRALITY**

LOC: ICF/MR

YEAR 1				
FACTOR D:	<u>\$23,060</u>		FACTOR G:	<u>\$74,249</u>
FACTOR D':	<u>9,244</u>		FACTOR G':	<u>5,361</u>
TOTAL	<u>\$32,304</u>	≤	TOTAL	<u>\$79,610</u>
YEAR 2				
FACTOR D:	<u>\$23,619</u>		FACTOR G:	<u>\$73,918</u>
FACTOR D':	<u>9,457</u>		FACTOR G':	<u>5,484</u>
TOTAL	<u>\$33,076</u>	≤	TOTAL	<u>\$79,402</u>
YEAR 3				
FACTOR D:	<u>\$24,163</u>		FACTOR G:	<u>\$77,161</u>
FACTOR D':	<u>9,675</u>		FACTOR G':	<u>5,610</u>
TOTAL	<u>\$33,838</u>	≤	TOTAL	<u>\$82,771</u>
YEAR 4				
FACTOR D:	<u>\$24,718</u>		FACTOR G:	<u>\$79,625</u>
FACTOR D':	<u>9,898</u>		FACTOR G':	<u>5,739</u>
TOTAL	<u>\$34,616</u>	≤	TOTAL	<u>\$85,364</u>
YEAR 5				
FACTOR D:	<u>\$25,287</u>		FACTOR G:	<u>\$82,154</u>
FACTOR D':	<u>10,126</u>		FACTOR G':	<u>5,871</u>
TOTAL	<u>\$35,413</u>	≤	TOTAL	<u>\$88,025</u>

Appendix H – HCBS Waiver Quality Management Strategy

I. Overview

California’s quality management strategy is evolving. Over the past ten years California has moved steadily toward a more integrated value-based quality management and improvement system that produces desired consumer outcomes. The evolving quality management system (QMS) is based upon the Centers for Medicare and Medicaid Services’ (CMS) Quality Framework. California’s QMS model incorporates and expands the basic concepts of the Quality Framework (Figure 1). At the core of the model is the consumer and family; all remaining system structures revolve around the central goal of “doing the right thing” for the people served by the system. Within the model, quality management starts with establishing clear expectations for performance (design), collecting and analyzing data to determine if the expectations are met (discovery), and finally, taking steps to correct deficiencies or improve processes and services (remediation and improvement).

The model is built upon the premise that quality assurance is not an “add on” to the work at hand, but an essential component of the manner in which the work is accomplished. It embodies the notion that discovery is a by-product of the work at hand and does not require participants in the system to generate special reports to satisfy the need to understand how the system is performing. Within this context, remediation and improvement will not only benefit the system, but will make the day-to-day work of the participants in the system more meaningful and effective.

To assure quality, the model will be applied at all levels of the system, the individual, regional center, provider and Department of Developmental Services (DDS). The model applies to the total developmental disability service delivery system, including individuals served under the Home and Community-Based Services (HCBS) Waiver.



California has excellent systems and structures in place that provide information and/or guide the QMS system. These include the automated Risk Management System, regional center performance contracts, the revised HCBS Collaborative Monitoring Review Protocol, the national core indicators pilot project, and the DDS Strategic Plan that is based upon widely accepted values for the system and individuals served by the system. However, there are structural gaps in the QMS, including limited access to system-wide consumer, provider-specific, and regional center information. This problem will be remedied by the implementation of the California Developmental Disabilities Information System (CADDIS) in 2008 in all 21 regional centers. CADDIS will provide a rich source of data with which to evaluate quality including measurements of service utilization, demographics, personal satisfaction and outcomes, consumer safeguards, and regulatory compliance. CADDIS will expand the State's ability to effectively measure the performance of the Waiver against the statutory requirements and Waiver assurances. CADDIS will equip California with an important tool to achieve continuous quality improvement.

I. HCBS Oversight and Administration

California administers the HCBS Waiver on three levels. The Department of Health Services (DHS) is the single State Medicaid agency and is responsible for approving policy direction, oversight and monitoring of programmatic and fiscal aspects of the HCBS Waiver. DDS operates the Waiver. In this role, DDS serves as the fiscal intermediary in payment for services as well as setting policy, overseeing and monitoring the Waiver implementation by the 21 regional centers that make up California's community based service delivery system. The 21 regional centers are non-profit corporations under contract with DDS. Regional centers are responsible for intake and assessment, including level of care determinations for the Waiver; service coordination; facilitating and participating in the development of plans of care known as Individual Program Plans (IPPs); coordination of services; assuring the health and safety of consumers in the community; recruiting and contracting with qualified providers to deliver services on the IPPs; monitoring implementation of the IPPs; and providing advocacy services for consumers and families.

II. Level of Care: *Individuals have access to home and community-based services and supports in their communities.*

3.1 Federal Requirements (Performance Expectations)

- An evaluation for level of care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.
- Enrolled participants are reevaluated at least annually or as specified in the approved Waiver. **Reevaluations of the IPP are performed when there is a significant change in the individual participant's condition or identified needs and/or at any time at the request of the consumer or authorized representative.**
- The process and instruments described in the approved Waiver are applied to determine level of care.
- The State monitors level of care decisions and takes action to address inappropriate level of care determinations.

3.2 Participant Roles and Activities

3.2.1 Consumers

Make choices with respect to participation in the HCBS Waiver. Exercise their due process rights when they disagree with the process or evaluation/reevaluation decisions.

3.2.2 Statewide Consumer Advisory Committee

The Statewide Consumer Advisory Committee is a 15-member committee that advises DDS on issues involving policies, programs, legislation and regulations affecting the delivery of services and supports to people with developmental disabilities in California. The membership of the Committee is representative of the geography, ethnicity, type of disability and living arrangements of individuals served by California's developmental disabilities service delivery system. To be eligible for membership, the individual must be a member of and be nominated by a local People First or self-advocacy group.

The Committee will be used as an advisory body to DDS on the effectiveness of the service delivery system in meeting the requirements of the HCBS Waiver related to participant access, participant-centered service planning and delivery, participant safeguards, participant rights and responsibilities, and participant outcomes and satisfaction. The committee will also advise on the provider capacity and capabilities in the areas that directly impact consumers. DDS will work collaboratively with the Committee to develop a Statement of their role and responsibilities with respect to the HCBS Waiver as well as performance expectations. The committee will play an important role in assisting DDS to gather input from consumers and incorporating the suggestions into the development of public policy and processes for the Waiver.

3.2.3 Regional Centers

In California, regional centers are responsible for conducting outreach activities to identify eligible individuals; perform level of care evaluations and reevaluations of all consumers that meet the basic criteria to participate in the HCBS Waiver. Regional centers are also responsible for assuring that the qualified personnel make the LOC decisions and that the LOC process and instruments described in the approved Waiver are in fact utilized and that consumers are fully informed of their due process rights. In this role, the regional center has primary responsibility for generating the basic instruments and data sources that will be used to measure the State's performance in this area. Quality begins with regional centers processes and as such the centers are responsible for assuring and monitoring quality in all of their operations.

When CADDIS is fully implemented, the basic instruments and data sources will be available in an automated database. This will increase the ability of the regional centers, DDS and DHS to monitor compliance and measure performance.

Regional centers are responsible for carrying out remediation and continuous quality improvement activities associated with the findings of the State's Biennial Collaborative on-site monitoring reviews and follow-up reviews.

3.2.4 Regional Center Performance Plan Development Process

All regional centers are required to enter into performance-based contracts with DDS. The contracts measure system and individual outcomes through 15 public policy performance measures and ten compliance measures. Each regional center is required to develop an outcome-based performance plan that addresses each of the public policy measures in collaboration with the community it serves. The plans must be developed through meaningful participation with the local community including at least one publicly noticed community meeting. The community meetings provide an excellent opportunity to gather information on the effectiveness of Waiver services from consumers and families, including their satisfaction with the services and suggestions for improvement. The suggestions and information is incorporated into local and State system design and direction/redirection of resources.

3.2.5 Department of Developmental Services

DDS has a dual responsibility in LOC. DDS not only monitors regional center LOC activities, but also provides policy direction, information and technical assistance. DDS assures consistency of application in LOC determinations through interpretation of the HCBS Waiver policies and identification of resources to carry out the responsibilities. These directives are transmitted to regional centers on a periodic basis.

DDS provides technical assistance and training to regional centers in best practice and remediation. One venue for the technical assistance is the quarterly meetings of the Association of Regional Center Agencies Federal Revenues Committee.

DDS in collaboration with DHS measures the regional center's performance in meeting the Federal requirements through the State's Biennial Collaborative on-site monitoring reviews and follow-up reviews. The reviews provide the information to trigger remediation and continuous quality improvement activities with respect to LOC.

3.2.6 Department of Health Services

Reviews and approves policy interpretations and directives that relate specifically to the HCBS Waiver. Monitors the LOC decisions in the State's Biennial Collaborative on-site HCBS Waiver monitoring reviews and follow-up reviews.

3.3 Sources of Data, Frequency of Measurement and Routine Reports (Discovery)

3.3.1 Biennial Collaborative On-Site HCBS Monitoring Review

The primary source of data used to measure performance is the State's Biennial Collaborative Monitoring Review conducted by DHS and DDS. The HCBS Waiver Monitoring Protocol includes consumer record reviews to ensure that qualified personnel appropriately document LOC evaluations and timely reevaluations. The Protocol also includes criteria to ensure that the assessment instrument [Client Development Evaluation Report (CDER)] in the approved Waiver is applied to LOC determinations and that the information contained in the CDER is reviewed annually. The appropriateness of the LOC determinations is also reviewed as a component of the on-site HCBS Monitoring Protocol. Reviewers verify that the information identified in the CDER is supported by and consistent with other information in the consumer's record.

The results of the monitoring reviews are discussed with the regional center at the end of the review. The State issues its draft Biennial Collaborative HCBS Monitoring Review Report to the regional center within 60 days of the close of the review. The draft report contains recommendations for corrective action as appropriate to improve performance and compliance. The regional center is required to submit its plan of action to the State for review and final approval. The State then finalizes and issues its formal report of the review to the regional center's Board of Directors.

Follow-up reviews are conducted for regional centers with deficiencies in the year following the biennial review. The purpose of the follow up reviews is to confirm and determine progress towards the actions regional centers identified in their responses to recommendations resulting from the previous year's monitoring review.

3.3.2 Other Discovery

DDS staff monitors on a monthly basis the regional centers' Waiver eligibility activity through the use of various automated reports. For example, the number of Waiver consumers served by each regional center is traced using the MWR 420M report to ensure that the maximum number of Waiver recipients is not exceeded. The report is emailed to regional centers.

Timeliness of regional center electronic reporting of annual reevaluations is monitored through use of the MWR 411 PO report. Recent data (11/04-3/05) indicates that system wide 99.4% of the reevaluations met the timeframe. Regional centers are notified monthly via e-mail of any overdue reevaluations. As needed, follow up letters are sent to regional center directors with a notification of overdue reevaluations and a date by which resolution must be achieved.

3.3.3 CADDIS

With CADDIS, regional centers and the State will be able to view and/or write reports on documents related to LOC. These include the Medicaid Waiver Eligibility Record and CDER report. The information will facilitate discovery activities on a continuous basis.

IV. Individual Plan: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community. Participants receive support to exercise their rights and in accepting personal responsibilities. Participants are satisfied with their services and achieve desired outcomes*

4.1 Federal Requirements (Performance Measures)

- Individual Plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by Waiver services or through other means.
- The State monitors plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of Individual Plans.
- Individual Plans are updated/revised when warranted by changes in the Waiver participant's needs.

- Services are delivered in the type, scope, amount, duration, and frequency and are delivered in accordance with the Individual Plan.
- Participants are afforded choice:
 - Between Waiver services and institutional care;
 - Between/among Waiver services and providers.

4.2 Participant Roles and Activities

4.2.1 Consumers

Consumers and, where appropriate, their legal representatives are the focal point and primary participants/decision makers in the development and implementation of individual plans. They have responsibility to exercise choice, to fully participate in the implementation of the individual plan, and to exercise their right to appeal decisions with which they disagree. Consumers are also the source of information on satisfaction with and quality of services and supports.

4.2.2 Statewide Consumer Advisory Committee

See 3.2.2.

4.2.3 Regional Centers

Regional centers are the link between consumers and needed services and supports. The individual plan represents the agreement between the consumer and regional center as to what services and supports are needed, the specific types and amounts of services and supports, the service providers and the duration of the services and supports. The individual plan is developed through a consumer driven person-centered planning process. The participant and, where appropriate, their legal representatives, a regional center service coordinator, and other persons invited by the consumer contribute to person-centered planning.

The regional centers' role in the planning process is to ensure that:

- Completed plans are based on a comprehensive assessment and information gathering process;
- Individual plans address all of the individual's assessed needs, including health and safety risk factors, and personal goals, either by HCBS Waiver services or other means;
- Individual plans specify the type, amount, duration, scope and frequency of services;
- Individual plans are reviewed at least annually, and modified as necessary, in response to the individual's changing needs, wants and health status.
- The individual is informed of and assisted in exercising his/her due process rights.

Regional centers are also responsible for monitoring the provision of services and supports to consumers to ensure that they are delivered in the manner prescribed in the individual plan, the consumer is satisfied with the services and supports, and that the services and supports continue to meet the individual's needs and wants. Advocacy is an important role for the regional centers to ensure that the consumer receives all services and supports from generic agencies and others in the service delivery system.

Regional centers produce the information used in discovery by DDS and DHS. Quality begins with the development of the individual plan and continues through its implementation. The regional centers are responsible for ensuring and monitoring quality in all of their operations, including the retention of trained, competent, qualified staff, and for making necessary changes to remedy problems and continuously improve quality. They are also responsible for initiating activities to gather feedback from consumers and other stakeholders to continuously improve their operations.

Regional centers are responsible for carrying out remediation and continuous quality improvement activities associated with the findings of the State's Biennial Collaborative on-site monitoring reviews and follow-up reviews.

At the present time, there is no Statewide information system that includes access to individual plans. CADDIS includes this feature and will use it as an important tool in discovery activities in the new Waiver. CADDIS also includes automated health information, plan reviews, case notes, denial of services, notices of action, and service activity. CADDIS increases the ability of the State and centers to monitor quality.

4.2.4 Service Providers

Service providers have a key role in supporting participants to achieve their identified goals and in implementing the individual plan. Service providers are responsible for participating on planning teams when invited. Service providers are responsible for delivering the services and supports in accordance with the individual plan, promoting and assisting consumers to exercise choice, gathering information on satisfaction and other service related issues from consumers and to use the information in quality improvements to service delivery. Service providers are responsible for ensuring and monitoring quality in their operations and for making necessary changes to remedy problems and improve quality.

4.2.5 Department of Developmental Services

DDS has a dual responsibility in development and implementation of individual plans. DDS not only monitors regional center IPP activities, but also provides policy direction, information and technical assistance. DDS assures consistency of application in development and implementation of IPPs through interpretation of the State mandates and HCBS Waiver policies and identification of resources to carry out the responsibilities. These directives are transmitted to regional centers on a periodic basis.

DDS provides technical assistance and training to regional centers in best practice and remediation. One venue for the technical assistance is the participation in meetings of the Association of Regional Center Agencies Chief Counselors.

DDS in collaboration with DHS measures the regional center's performance in meeting the Federal requirements through the State's Biennial Collaborative on-site monitoring reviews and follow-up reviews. The reviews provide the information to trigger remediation and continuous quality improvement activities with respect to individual plans.

4.2.6 Department of Health Services

Reviews and approves policy interpretations and directives that relate specifically to the HCBS Waiver. Monitors the development and implementation of individual plans through the State's Biennial Collaborative on-site HCBS Waiver monitoring reviews and follow-up reviews.

4.3 Sources of Data, Frequency of Measurement and Routine Reports (Discovery)

4.3.1 Biennial Collaborative On-Site HCBS Monitoring Review

The primary source of data used to measure performance related to individual plans is the State's Biennial Collaborative on-site HCBS Monitoring Reviews and follow-up reviews conducted by DHS and DDS. The HCBS Waiver Monitoring Protocol includes consumer record reviews to ensure that individual plans are complete and meet Waiver requirements. The review includes criteria to assure that individual plans:

- Address the consumer's needs and personal goals and identify all services and supports (regardless of funding source) that address the needs and goals in accordance with State policies;
- Are reviewed at appropriate intervals (at least annually) and revised when necessary;
- Document choice between Waiver services and institutional care through completion of a signed Medicaid Waiver Consumer Choice of Services/Living Arrangements form;
- Document choice of services and providers through consumer participation in the development of Individual plans and/or plan addenda; and
- Document plan/addenda agreement through a signature of the consumer or, where appropriate, his/her legal representative.

The review also verifies the State regulation that service coordinators meet quarterly with consumers who do not reside with their families to assess the provision of services in relation to the IPP and to determine if any changes in services are needed. Documentation of the outcome of these meetings is also required.

The on-site monitoring review includes interviews with service coordinators, to gather additional information on the ongoing assessment of need, development of IPPs, monitoring of services and supports, and special incident reporting. The reviews include interviews with service providers and direct care staff to determine their participation in ongoing assessment of need, participation in the development of IPPs, actual provision of services, responses to emergencies and other issues. One of the most important parts of the service coordinator, service provider and direct support staff interview is a series of questions to determine how well the service coordinator knows the consumer. It is felt that this knowledge is an important indicator of quality in the service delivery system.

The on-site review includes interviews with and observations of consumers in their day and residential programs. The purpose of the interviews is to determine satisfaction with and opinions about their service and supports, including service coordination. **Service coordination, case management and client program coordinators are synonymous and used interchangeably in the California system. A case manager or service coordinator is assigned to each regional center consumer.**

Follow-up reviews are conducted for regional centers with deficiencies in the year following the biennial review. The purpose of the follow up reviews is to confirm and determine progress towards the actions regional centers identified in their responses to recommendations resulting from the previous year's monitoring review.

The report process is described in 3.3.1.

4.3.2 DDS and DHS Focused Reviews

DDS and/or DHS performs focused reviews at regional centers where there are on-going difficulties complying with State mandates and Waiver requirements. The focused reviews provide additional discovery information to more effectively develop remedial activities such as training and technical assistance.

4.3.3 Risk Assessment/Mitigation and Person-Centered Planning/Individual Program Plan Tools Developed and Distributed by DDS

The State has provided regional centers with an individualized risk assessment tool. The tool was provided to regional centers in both hard and electronic formats in August 2002. A second individual risk tool was sent to regional centers in January 2004.

Additional tools and information are available to regional centers, service providers and the community at-large at www.ddssafety.net and on the DDS homepage at www.dds.ca.gov.

4.3.4 Additional Discovery Efforts

The new Waiver will include additional discovery efforts in the area of consumer and family satisfaction and suggestions for improvements in service delivery. The on-site monitoring review will include an interview with family members of children served in the HCBS Waiver. The active participation of the State's Consumer Advisory Committee at its quarterly meetings and the information gathered by regional center Boards of Directors in the community meetings held to develop the annual performance plans would provide important information on the quality of Waiver services. All of the information gathered through the consumer interviews, family interviews, Consumer Advisory Committee activities, and the Boards of Directors will be analyzed and incorporated into setting policy direction for the service delivery system, including the administration of the Waiver.

4.3.5 Performance Contracts

Performance contracts measure progress on public policy and compliance measures against baseline data for each center. The public policy measures include the number of minors residing with families and the number of adults residing in home settings. The compliance measures include certification to participate in the Waiver, substantial compliance with DDS fiscal audit, unqualified independent audit, compliance with vendor audits, intake/assessment time lines, and IPP development. The contracts are calendar year contracts. DDS provides the baseline data to each regional center in a draft year-end report at the end of February for use in the current year contract. DDS provides semi-annual data reports based on Client Master File and CDER data for relevant public policy and compliance measures to regional centers by July 15th and January 15th in the contract year so that the regional centers will know how they are doing in achieving each measure. The semi-annual reports are provided in draft form to the regional centers one month prior to the dates for review and comment. At the end of the contract period, DDS reviews

baseline and year-end performance data for the statewide public policy and compliance measures for each regional center and provides this information to each regional center in their individualized year-end reports. A regional center would be considered to have successfully achieved an item upon demonstrating that the outcome has improved over the prior year's baseline; or the performance exceeds the statewide average; or the performance equals a standard that has been defined by DDS.

4.3.6 CADDIS

With CADDIS, regional centers and the State will be able to view and/or write reports contemporaneously on documents related to individual plans. The data that will be in CADDIS includes the individual plan, Medicaid Waiver Eligibility Record, CDER report, health information, plan reviews, case notes, denial of services, notices of action, and service activity. The information will facilitate discovery activities on a continuous basis.

V. Qualified Providers: *(There are sufficient HCBS Providers and they possess and demonstrate the capability to effectively serve participants)*

5.1 Federal Requirements (Performance Measures)

- The State verifies on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other State standards.
- The State monitors non-licensed/non-certified providers to assure adherence to Waiver requirements.
- The State identifies and rectifies situations where providers do not meet requirements.
- The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved Waiver.

5.2 Participant Roles and Activities

5.2.1 Service Providers

Service providers are responsible for maintaining the required license, certification, academic degree, and other qualifications set in CCR Title 17 and Title 22. Providers are responsible for recruiting, training and retaining qualified staff to provide services and supports to participants. Providers are responsible for operating in accordance with their programmatic service design or description and in accordance with accepted business practices including maintaining records of services provided to consumers in sufficient detail to verify delivery of the billed units of services. Providers must sign a Home and Community-Based Services Provider Agreement with the regional center as a condition of being vendored.

5.2.2 Regional Centers

Vendorization is a requirement to provide services and supports to consumers. Regional centers are responsible for vendoring service providers who meet the qualifications set in CCR Title 17. Vendorization is the process that establishes a contract between the regional center and a prospective service provider. Service providers must be vendored separately for each service they provide and must meet the qualifications set for each service. The vendorization process includes submission of all information, including licenses, credentials, certificate or permit, academic degree required for the performance or operation of the

service. For specified programs (e.g., day, residential, respite, habilitation, supported living, family home agency, etc.) a program design is required along with the proposed or existing staff qualifications and duty Statements. A signed Home and Community-Based Services Provider Agreement is a requirement of vendorization.

Regional centers provide initial and ongoing training to service providers on topics including Title 17 regulations.

Regional centers are responsible for monitoring the programmatic and fiscal performance of qualified providers and to initiate corrective actions that may result in sanctions when deficiencies are found. In most cases deficiencies in performance can be corrected through technical assistance and training. Regional centers may review the vendor files annually to determine, among other things, that the vendor meets the minimum program standards and that the information required for vendorization is complete and accurate.

CADDIS will assist the regional centers in their responsibilities to maintain and monitor a pool of qualified providers. The system includes 36 provider-related reports including notification of license expiration, utilization reviews, various vendorization reports, monitoring reports, sanctions, rates, etc.

5.2.3 Department of Developmental Services

DDS is responsible for setting the qualifications for service providers through the regulatory process. DDS is also responsible for fiscal and programmatic oversight and monitoring of regional centers including service provider performance related to the qualified provider Waiver assurance.

DDS developed and funds the Direct Support Professional Training program as a part of the State's efforts to continuously improve quality services. DDS also provides training and technical assistance to regional centers for distribution to their staff as well as providers.

5.2.4 Department of Social Services Community Care Licensing (DSS/CCL)

DSS/CCL is responsible for licensing community care facilities and day programs in accordance with CCR Title 22. Title 22 establishes qualifications for providers in those categories. DSS/CCL monitors the performance of licensees at least annually and identifies and follows up on any deficiency that is identified during monitoring visits. Licenses must be renewed annually.

5.2.5 Department of Health Services

Reviews and approves policy interpretations and directives that relate specifically to the HCBS Waiver. Monitors the development and implementation of individual plans through the State's Biennial Collaborative on-site HCBS Waiver monitoring reviews and follow-up reviews

5.3 Sources of Data, Frequency of Measurement and Routine Reports (Discovery)

5.3.1 Biennial Collaborative On-Site HCBS Monitoring Review

The State's Biennial Collaborative on-site HCBS Monitoring Reviews and follow-up reviews conducted by DHS and DDS includes monitoring qualified providers through record reviews,

site visits and evaluations, and interviews with service providers and direct support staff at community care facilities and day programs. The monitoring protocol includes criteria to evaluate that consumer records are maintained and include documentation of the provider's monitoring of consumer progress toward achievement of the IPP services for which the provider is responsible, and evidence of appropriate reporting of, and response to special incidents. Prior to the on-site visits the review team reviews vendor files and interviews quality assurance staff.

The review team makes on-site visits to day programs and community care facilities during the second week of the review. The visits include observations; interviews with consumers, providers and direct support staff; record reviews and a review of the physical site. The purpose of the visits is to insure that consumers are served in safe, health, positive environments where consumer rights are respected.

The service provider and direct support staff interviews are conducted to determine that they are knowledgeable regarding the care needs of the individual's IPP for which they are responsible and that these services are being delivered; knowledgeable of and responsive to the health and safety/well-being needs of the consumer(s); and aware of their responsibilities for risk mitigation and reporting. The interviews also ask questions regarding how well the service provider and direct support staff know the consumer. This is considered to be one of the most important measures of quality.

Follow-up reviews are conducted for regional centers with deficiencies in the year following the biennial review. The purpose of the follow up reviews is to confirm and determine progress towards the actions regional centers identified in their responses to recommendations resulting from the previous year's monitoring review.

The report process is described in 3.3.1.

5.3.2 Department of Developmental Services Adult Family Home Agency (AFHA) Monitoring Reviews

Regional centers evaluate AFHAs annually for regulatory and contract compliance. DDS staff periodically monitors and evaluates program implementation by the regional center, AFHA, and family home providers. Documentation is provided to DDS on all issues identified.

5.3.3 Department of Developmental Services and Regional Center Monitoring of Habilitation Services Programs

DDS and the vendoring regional center have the responsibility for monitoring and evaluating Habilitation Services Programs for service quality, protections and CARF standards for consumers receiving services; verification of ongoing CARF accreditation. When noncompliance is identified, the service provider is required to develop a corrective action plan within 30 days notification by DDS or the regional center of noncompliance and the sanction. The sanctions include a moratorium on new referrals, or imposition of a corrective action plan, or removal of consumers from the program.

5.3.4 Department of Social Services Community Care Licensing (DSS/CCL) Monitoring

5.3.4.1 Annual visits

In July 2003 as a part of the Budget Act, DSS/CCL moved from an annual visit to all community care facilities to a comprehensive visit to a required 10% random sample of facilities each year plus a 10% sample of facilities. However, the accompanying statutes included specific exceptions to the new process.

Exceptions included facilities that served individuals with developmental disabilities so as not to jeopardize the federal waiver that requires annual facility visits.

To accomplish this task, the Facilities Automated System used by DSS/CLL to track and enter all facility visit information was reprogrammed to allow a designation for individuals with developmental disabilities to be entered for any facility. When the specific code is entered, the computer automatically designates that facility for an annual visit. The annual visit schedule is based on the initial date of licensure of the facility.

In the annual comprehensive visit DSS/CCL includes a thorough review of case files kept in the licensing office to determine the scope of the current visit to the facility. The review includes an overview of the history of the facility, an analysis of any complaints, investigations and actions taken, including monitoring reports of plans of correction, reports on follow-up visits, and regional center evaluations.

5.3.4.2 Other visits

DSS/CCL also conducts prelicensing visits to ensure that a facility meets regulatory requirements before it is licensed; post licensing visits to ensure the facility is starting its operation in compliance with regulations after it is operating and consumers are present; and caseload management visits any time it is felt an extra monitoring visit is warranted.

All complaints lodged against a facility that alleges a violation of a licensing regulation results in a visit to the facility within ten days of the receipt of the complaint.

5.3.4.3 Provider deficiencies

Any type of visit that results in a deficiency of a regulation being found requires that a plan of correction be developed. All corrective action plans require follow-up to ensure that the correction was made. In some cases, this can be accomplished by the licensee sending in proof of correction. Where that cannot be done, a Plan of Correction visit is required. At times a new deficiency is found during the Plan of Correction visit. If this is the case, a subsequent plan of correction visit will take place and continue to take place until all corrections are made.

DSS has several enforcement tools available when corrections are not made. These include civil penalties (fines) when deficiencies are not corrected or when the same deficiency occurs repeatedly; compliance conferences in which the licensees are given a tightly monitored plan and schedule to move the facility into substantial compliance and formal action to deny an application, revoke or suspend a license, or exclude an individual.

Representatives from CDSS and DDS have been meeting quarterly for several years pursuant to their Memorandum of Understanding. DHS representation to these meetings was added in 2005. This committee meets quarterly and/or on an as-needed basis to bring non-compliance concerns and issues to the attention of DSS and to discuss Waiver Compliance Monitoring Review findings.

5.3.5 Provider Training

5.3.5.1 Department of Developmental Services Direct Support Professional Training Program (DSPT)

Since January 1999 there has been a mandatory competency-based training program for all direct support staff and administrators who provide direct support working in licensed community care facilities. The training is a 70-hour standardized competency based training divided into two 35-hour segments that are to be included over a two-year period or through a challenge test. Training topics include risk management and incident reporting, maintaining the best possible health, medication management, identify the signs and symptoms of illness and injury, oral health, positive behavior supports, person-centered planning, and nutrition and exercise.

The training has a built in continuous quality improvement component. A contractor evaluated the DSP training program in 2002. Recently, DDS revised the DSP curriculum in recognition of the pivotal role direct support professionals play in the service delivery system; as part of the State's efforts to continuously improve quality services; in response to HCBS Waiver Monitoring Review findings; and in response to special incident reporting data and reports from the State's independent risk management contractor.

At the 2005-2006 annual conference on May 9-10, 2006, CMS' Guidelines for Psychopharmacologic Medications will be introduced to the trainers of the DSPT to assure that caregivers and program reviewers are aware of validated best practices on the use of psychotropic medications.

5.3.5.2 Department of Developmental Services other training and technical assistance

DDS offers training materials and technical assistance to regional centers on identified issues related to qualified providers.

5.3.5.3 Department of Social Services

Administrators and applicants/licensees are required to take a 40-hour course from an approved trainer and pass a written test with a score of 70 percent or above to be a qualified administrator/licensee. There is a two-year re-certification requirement of an additional 40-hours of training. Applicants must have a training plan in their facility operational plan for each new and continuing staff working in the community care facility for each application. DDS/CCL staff monitors this requirement during annual visits.

5.3.5.4 Regional Centers

Title 17 requires regional centers to provide residential services orientation for all persons who wish to become vendorized to provide residential services. The orientation is given at least every six months and includes an overview of Title 17 requirements, an overview of the self-assessment process and the individual life quality outcomes identified in the

“Looking at Service Quality Provider’s Handbook” and its relation to Title 17. The administrator must complete the orientation before admission of the first regional center consumer or when two or more years have elapsed since he/she last served as an administrator.

5.3.6 Regional Centers

5.3.6.1 Selection criteria for individual plan service providers

Regional centers are responsible for monitoring the progress toward meeting IPP objectives for all providers. One of the factors in evaluating the progress is the determination that the provider is in fact able to deliver the services prescribed on the individual’s plan. The Lanterman Act provides that the regional center and consumer, or her or her authorized representative must consider the providers ability to deliver quality services or supports which can accomplish all or part of the individual’s plan, the provider’s success in achieving the objectives set forth in the IPP, the cost of providing services of comparable quality by different providers, and the individual’s choice of providers. The Act further provides that no service or support provided by any agency or individual shall be continued unless the individual, or where appropriate, his or her authorized representative, is satisfied and the regional center and individual or authorized representative agrees that planned services have been provided and that reasonable progress toward objectives has been made.

Regional centers perform fiscal audits on a sample of vendors each year.

5.3.6.2 Facility liaison

Regional centers are required to designate a facility liaison to all licensed community care residential facilities. The liaison is responsible for monitoring consumer services and providing technical assistance to the facility. The liaison is required to complete a minimum of one monitoring visit each year to review staff schedules for compliance with the approved service level requirements; review personnel training files to assure compliance with the facility design and level; select and review a randomly chosen sample of 20 percent of the consumer records to ensure that services were provided in accordance with the service design and IPP and that all required documents and reports are complete and current; review individual life quality outcomes and self-assessment with the administrator; and review Level 4 program design with the administrator to determine program effectiveness in achieving IPP objectives. The liaison may also inspect the grounds, buildings and services. If the monitoring review finds deficiencies, the administrator can be required to develop a corrective action plan that is then monitored by the liaison. Title 17 regulations define deficiencies and sanctions in two categories: substantial and immediate danger (deficiencies that pose a threat to the health and safety of a consumer and must be corrected within 24 hours). Each category has actions that can be applied as described below.

5.3.6.3 Quality Assurance Monitoring Plans

Regional centers are also responsible for developing, implementing and maintaining a quality assurance plan to monitor licensed and vendored community care facilities a minimum of once every three years. The monitoring entails a review of facility records at the regional center and facility for compliance with required documentation; review of randomly selected consumers’ record at the facility and regional center for compliance with

required documentation; observation of consumer activities during regularly scheduled daily activities for compliance with the program design and the IPP objectives; talking to consumers living at the facility and authorized representatives to determine their satisfaction; and assess effectiveness of the facility in assisting consumers to achieve the individual life quality outcomes. Within five days of completing the review, the preliminary findings are presented to the administrator. An opportunity is given for the administrator to respond. Appropriate technical assistance is given to the facility. Within 30 days the administrator is given the written results of the monitoring visit that includes findings of compliance and non-compliance and the process for securing needed technical assistance and/or training. At times the findings include a corrective action plan for improvement.

5.3.6.4 Corrective action plans (CAP) and sanctions

Within ten working days of a finding of a substantial inadequacy, the regional center and administrator meet to develop a written corrective action plan that describes the substantial inadequacy; cites the applicable statute, regulation, IPP or Admission Agreement requirement; and informs the administrator of his/her right to appeal. The plan also details the methods by which the administrator is to correct the deficiency. Correction is to take place within 30 days from the development of the CAP unless the regional center determines that it will take longer in which case the CAP shall establish interim review dates. The total time period cannot exceed six months. The CAP is presented to the administrator within two working days of the meeting with copies to DSS/CCL when appropriate. CAPs are also sent to other regional centers that have placed consumers in the facility. The administrator must return the signed CAP within seven days of its receipt. The follow-up monitoring is done by the facility liaison.

Sanctions are applied when the facility fails to correct the substantial inadequacy within the specified timeframe or when there are two findings of substantial inadequacies in the same facility within any 12-month period. Sanctions include reducing the service level, counseling consumers to move, or not placing consumers in the facility, or offset or recover a portion of the rate intended for direct care staff training. When the issue is an immediate danger, it must be corrected within 24 hours or the consumer is relocated.

5.3.7 Service Providers

Service providers are responsible for assuring quality in their programs including meeting all regulatory requirements. In home respite agencies, community day programs, and supported living programs are required to perform an annual evaluation of program effectiveness in relation to the program design. The evaluation must include aggregate data on progress in relation to the IPP objectives for which the vendor is responsible, the type of data collected, the frequency of data collection, and the data. It must also include a description of the distribution, communication of, and actions taken upon the results of the evaluation.

5.3.8 Department of Health Services

Reviews and approves policy interpretations and directives that relate specifically to the HCBS Waiver. Monitors the development and implementation of individual plans through the State's Biennial Collaborative on-site HCBS Waiver monitoring reviews and follow-up reviews.

VI. Health and Welfare: (*Participants are safe and secure in their homes and community, taking into account their informed and expressed choices. Participants are satisfied with their services and achieve the desired outcomes*)

6.1 Federal Requirements (Performance Measures)

- The State, on an on-going basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.

6.2 Participant Roles and Activities

6.2.1 Service Providers

Service providers have a primary role in safeguarding the health and safety of consumers. The responsibility includes assisting the consumer to maintain an optimum health status and assisting the consumer to exercise his or her rights to be free from harm and to be a full participant in the life of the community through implementation of the Individual plan. In addition, State regulations require service providers to report incidents of: suspected abuse, neglect, and/or exploitation; serious illnesses and injuries; unplanned or unscheduled hospitalizations; missing consumers; deaths; and crime victimization to regional centers immediately but no later than 24 hours of the occurrence.

6.2.2 Regional Centers

Regional centers have a primary role in ensuring that the health and safety of consumers is safeguarded. The regional center is responsible for developing and monitoring the Individual plan that identifies the wants and needs of the consumer in all areas, including health and safety. The regional centers are responsible for monitoring the individual plans and the implementation of objectives related to health and safety for consumers. The regional centers accomplish this through quarterly and/or annual reviews.

The 21 Regional centers have local-level responsibility for planning, coordinating and implementing the risk management program by:

1. Implementing and reviewing the regional center risk management and prevention plan.
2. Developing and implementing local and individual risk prevention strategies based on trends identified through the analysis of the SIR data.
3. Coordinating with other agencies (e.g., licensing, protective services, law enforcement agencies, coroners, long-term care ombudsman, etc.) to gather and review the results of their investigations and using this information to prevent the recurrence of similar problems.
4. Conducting on-site and chart review activities to gather and report initial and follow-up SIR information.
5. Providing training and technical assistance to staff, providers, and others so as to improve quality of life outcomes for consumers.

6.2.3 Department of Developmental Services

DDS has overall State-level responsibility for planning, coordinating and overseeing implementation of the State's risk management program for persons with developmental disabilities. These responsibilities include:

1. Maintaining a uniform, statewide, automated Special Incident Report (SIR) database system, and reviewing SIRs daily to identify issues or concerns requiring additional follow-up.
2. Aggregating and analyzing SIR data by regional centers, risk indicators, client characteristics, programs, incident types, corrective actions, residence, and other relevant factors, and providing such data to the risk management contractor for further analysis and to regional centers for follow-up, as appropriate.
3. Providing training and technical assistance to regional centers to educate and inform the service system so as to improve quality of life outcomes for consumers.
4. Maintaining a statewide mortality review system.
5. Utilizing risk management data in the Department's Quality Management Executive Committee quarterly meetings to develop statewide quality improvement policies.

6.2.4 Risk Management Contractor

The State engages the services of an independent, specialized risk management and mitigation contractor possessing a multidisciplinary (clinical, research, data analysis, training, business) capacity to perform the following activities:

1. Review and analyze DDS SIR data to identify statewide, regional and local trends requiring further analysis, departmental, or regional center action.
2. Conduct reviews based on data analyses and as directed by DDS to obtain qualitative health and safety risk data on incident trend pattern(s).
3. Perform ongoing review and analysis of the research and current literature with respect to preventing accidents, injuries, and other adverse incidents.
4. Develop and disseminate periodic reports and materials to the field (providers, regional centers, families, disability organizations, etc.) on best practices related to protecting and promoting the health, safety, and well-being of consumers.
5. Maintain a website (www.ddssafety.net) for consumers and their families, providers, professionals, and regional center staff. The site includes information from across the nation on current research and best practices and practical information directed towards improving consumers' health and safety.
6. Assist DDS in planning, coordinating, and providing statewide training related to risk management and other related topics.

7. Provide on-site technical assistance to regional centers related to local risk management plans and activities.
8. Conduct mortality reviews.

6.2.5 Department of Social Services Community Care Licensing (DSS/CCL)

As discussed in the previous section, DSS/CCL monitors licensed community care facilities and day programs. The Title 22 regulations requires licensees to report deaths as a result of injury, abuse, or other than natural causes; the use of an automated external defibrillator; injuries that require medical treatment; unusual incidents or client absences that threatens the physical or emotional health or safety of the consumer; suspected abuse; epidemic outbreaks; poisonings; catastrophes or fires or explosions on the premises. Death certificates are sent to the regional centers. Reports are to be made immediately with a written report submitted in next working day and a follow-up report submitted within seven working days.

6.2.5 Other Protective Agencies

California has other protective services agencies that play a part in the health and safety of consumers and other citizens. These include Child Protective Services and Adult Protective Services. Regional centers are required to send copies of SIRs to these agencies when appropriate.

6.3 Sources of Data, Frequency of Measurement and Routine Reports (Discovery)

6.3.1 Statewide Risk Management and Mitigation System Monitoring

DDS reviews daily SIR electronic transmissions from regional centers for regulatory compliance and to ensure proper notifications have been made to legally required entities. DDS monitors regional center compliance with SIR regulatory reporting requirements and provides technical assistance to regional centers as needed. DDS provides immediate and ongoing feedback to the regional centers. DDS Regional Center Branch SIR/Risk Management holds monthly meetings to discuss and share SIR data and analyses. DDS sends compliance letters to regional centers as a result of the monthly data reports.

The Independent Risk Management Contractor performs reviews and analysis of the SIRS and develops mitigation strategy recommendations for DDS. The data, analysis and recommendations have resulted in numerous preventive strategies for mitigating risk. These include training conferences for regional centers and service providers, development of training curriculums, development and distribution of consumer-focused risk management/prevention tools, and quarterly newsletters and a website (www.ddssafety.net) dedicated to health and safety topics for consumers, families, service providers and regional centers.

The Risk Management Contractor also analyzes special incident report data for trends and the development of best/practice/risk mitigation strategies for DDS and regional center consideration and provides technical assistance to regional centers and service providers. The contractor prepares specialized reports such as "Preliminary Analysis of Reports of Suspected Neglect".

Mortality reports are posted on DDS website. The independent contractor conducted focused on-site reviews of mortality at two regional centers at the request of DDS.

6.3.2 Biennial Collaborative HCBS Monitoring Review

A Regional Center Self Assessment is completed by each regional center prior to the on-site monitoring visit. The self-assessment gathers information on the center's Risk Management, Assessment and Planning Committees and Risk Management/Mitigation Plans. The on-site monitoring includes a review of the regional center's special incident reporting and risk mitigation process. The on-site review includes interviews with clinical staff, service coordinators, quality assurance staff, service providers and direct support staff. The interviews contain questions about special incident reporting, the use of the trend data to improve services, and the role of the clinical staff. There are also record reviews to determine that service providers and regional centers have taken appropriate measures to mitigate consumer risk in response to a special incident.

The report process for the biennial reviews is discussed in 3.3.1

6.3.3 Focused reviews

On occasion DDS and/or DHS perform focused reviews of SIR reporting based upon information gathered on an ongoing basis and through the biennial reviews.

6.3.4 Department of Social Services Community Care Licensing

6.3.4.1 Complaint visits

All complaints lodged against a facility that alleges a violation of a licensing regulation results in a visit to the facility within ten days of the receipt of the complaint.

6.3.4.2 Caregiver background checks by DSS/CCL.

The licensing program protects consumers by screening out unqualified applicants and individuals associated with facilities. DSS/CCL implements this protection by requiring that individuals receive a fingerprint-based check of their criminal history from both the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). The background check for individuals associated with children's facilities also includes a required check with the Child Abuse Central Index maintained at the DOJ. Certain serious crimes specifically exclude someone from working or being in a facility. For other crimes, if criminal history information indicates a conviction, the DSS/CCL evaluates the individual's history to determine if the individual can be involved in a licensed facility. DSS/CCL investigates the circumstances of any arrest to determine if the allegations can be substantiated according to licensing standards. An approved background check is required prior to employment in a facility.

6.3.4.3 Disclosures

Recent law requires sex offenders (adults and children) to disclose this fact to licensees before becoming a facility client.

VII. Administrative Authority

7.1 Federal Requirements (Performance Measures)

- The Medicaid Agency or operating agency conducts routine, on-going oversight of the Waiver program.

7.2 Participant Roles and Activities

7.2.1 Department of Health Services

DHS is California's Medicaid Single State Agency. As such DHS reviews and approves required reports, and ensures the Waiver program and services are implemented in accordance with Medicaid statute, regulations and Waiver requirements.

7.2.2 Department of Developmental Services

DDS is the operating agency for the Waiver and as such is responsible for implanting the requirements of the Waiver under DHS oversight and through the 21 regional centers.

7.3 Sources of Data, Frequency of Measurement and Routine Reports (Discovery)

7.3.1 Routine State-Level Sources of Data

- State's Biennial Collaborative On –Site HCBS Waiver Monitoring Reviews
- State Teams Follow-up HCBS Waiver Monitoring Compliance Reviews
- Statewide Risk Management/Mitigation Database
- DDS contract for Life Quality Assessments
- DDS Regional center Performance Contracts
- DDS Fair Hearing Data Base
- DDS Consumer Complaint Process

7.3.2 Regular Meetings and Reports

- DDS Quarterly HCBS Waiver Reports to DHS
- DDS, DHS and DSS quarterly meetings
- DDS, DHS HCBS Waiver coordination meetings

7.3.3 Other Monitoring Activities - Department of Health Services

- As the Medicaid Single State Agency, DHS conducts independent focused reviews to investigate significant special incident reports, consumer/advocate complaints, or CMS concerns/requests for investigation.
- DHS reviews DDS Quarterly HCBS Waiver Reports to determine whether established policies and procedures are appropriately and adequately implemented by DDS to monitor the regional centers' compliance with Waiver requirements.
- DHS will participate in the standing DDS Executive Management Quality Management Committee meetings.

7.3.4 Other Monitoring and Continuous Quality Improvement Activities – Department of Developmental Services

- DDS Executive Quality Management Committee Meetings and Activity
- DDS training/technical assistance to regional centers including presentations to the Association of Regional Center Agencies Chief Counselors and Federal Revenues Committees focusing on the CMS expectations of States and the Biennial Collaborative On-Site Monitoring Protocol that was enhanced to conform with CMS expectations and transition to the quality framework.
- Allocation of additional resources to regional centers to add a Federal Program Coordinator position at each regional center.
- Life Quality Assessment Rapid Response Reports to the State Council on Developmental Disabilities. DDS follows-up with regional centers on allegations of service and/or civil rights and health and safety concerns discovered through the LQA process.
- Regional Center Performance Contracts and Year-End Assessment and Report
- DDS follow-up on Fair Hearing Trends
- DDS investigates and issues final administrative decisions in the Welfare and Institutions Code §4731 complaint process.

VIII. Financial Accountability

8.1 Federal Requirements (Performance Measures)

- State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved Waiver.

8.2 Participant Roles and Activities

8.2.1 Department of Health Services

DHS Audits and Investigations (A&I) Division is assigned responsibility for fiscal oversight of the Waiver. DHS A&I works collaboratively with DDS and the DHS programmatic division and independently to ensure the Waiver program and services are implemented in accordance with Medicaid statute, regulations and Waiver requirements. The responsibilities include monitoring DDS compliance with fiscal provisions relative to audits of regional centers; review DDS audit protocol to ensure compliance with the Waiver; ensure that DDS audits of regional centers are conducted on a biennial basis; ensure that audits conducted by DDS are in accordance with established protocols and meet Generally Accepted Government Auditing Standards requirements; refer and follow-up any program integrity issues identified during oversight activities to DHS and to DDS for investigation, and to DDS Audits and DHS Medi-Cal Policy Division for information; review working papers prepared by DDS audit staff of regional centers on a sample basis and attend entrance and exit conferences of selected regional center audits; participate in full-scope monitoring as required; and issue an annual report to DHS Director and to CMS that summarizes oversight functions performed.

DHS conducts, on an annual basis, a random sample review of the regional center vendor audit reports. DHS also oversees DDS' monitoring of regional center compliance with conducting vendor audits in accordance with the distributed protocols and assures

appropriate fiscal follow-up and remediation activities occur as required in both the RC and DDS audit activities in accordance with the State's Waiver.

8.2.2 Department of Developmental Services

DDS performs fiscal audits of each regional center no less than every two years, and completes follow-up reviews of each regional center in alternate years. DDS requires regional centers to contract with independent auditors to conduct an annual audit. The DDS audit is designed to "wrap around" the independent CPA audit to ensure comprehensive financial accountability. DDS coordinates its activities with DHS A&I, who review DDS' audit reports of regional centers.

DDS performs fiscal audits of regional center vendors. DDS also operates a billing and payment system.

8.2.3 Regional Centers

Regional centers perform billing/cost verification and staffing audits of vendors.

8.3 Sources of Data, Frequency of Measurement and Routine Reports (Discovery)

8.3.1 State's Biennial Audits of Regional Centers

The audits are conducted by DDS audit staff and reviewed by DHS A&I prior to finalization. DDS provides DHS with a Pre-Audit Review package containing DDS contracts and contract budgets summary; summary of regional center budget; summary of State claims; summary of advances and offsets; CPA audit reports; and the DDS review of CPA work papers. After the review, DHS forwards a copy of each final DDS Biennial Regional Center Audit to CMS on a flow basis.

DHS annually submits a final report to CMS on A&I's fiscal oversight for the year. DDS routinely issues the audit reports to regional center Boards of Directors.

8.3.2 Other Financial Audit Reports

- Annual Independent CPA audit of regional centers
- Fiscal audits of regional center vendors

8.3.3 Other Monitoring

DHS follows up on problem areas identified by CMS and other problem areas such as the decertification of a regional center based upon financial activities.

DDS reviews each regional center's annual CPA report and follows up with the regional center regarding corrective action for each management comment identified in the report.

DDS reviews regional center vendor audits for compliance with requirements in Title 17 and the regional center contract. DDS in conjunction with the Association of Regional Center Agencies developed a set of standard vendor audit protocols for the regional center vendor audits and works with the regional centers to improve the quality of the audits.